chiropractic

Bringing Out The Best In You!

SHAWN P. NEVILLE, DC
Kennedy Chiropractic
4140 Crain Highway
Waldorf MD 20603
301.645.7770
drneville.com
drshawn@drneville.com

New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____
Address _____
City/State/Zip _____
Phone #s (home) _____ (cell) _____
Email address _____
SS # _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Is it okay to contact you at work? ❍ no ❍ yes Work # _____
Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed
Spouse/Partner Name: _____
Phone #(s) _____
Is it okay to text you? ❍ no ❍ yes
Favorite hobbies or interests _____
Emergency contact: Name _____
Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes
If yes, please tell us who _____ Phone # _____
Were you pleased with your care? ❍ no ❍ yes
How did you find out about our office? _____
Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____
When did the incident occur? _____
Attorney (if applicable) _____ Phone # _____
Are you receiving care from other health professionals? ❍ no ❍ yes
If yes, please name them and their specialty _____
_____
Please list any drugs or medications you are taking _____
_____
Please list any vitamins/herbs/homeopathics/other you are taking _____
_____
_____
Are you pregnant? ❍ no ❍ yes If yes, what month? _____

Current Health

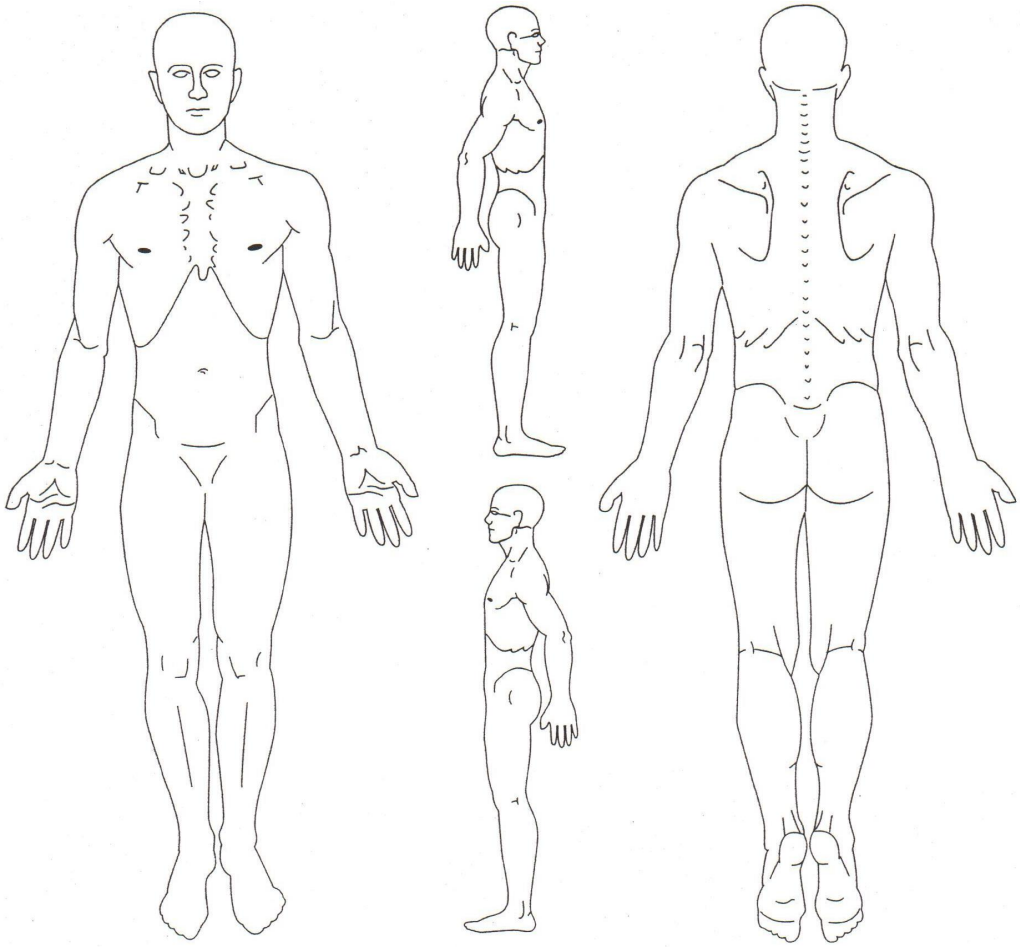
What are your pressing health concerns? _____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the pain you are experiencing. **D**=Dull **B**=Burning **N**=Numb **S**=Stabbing/Cutting **T**=Tinging/Cutting **C**=Cramping



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain _____

_____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain _____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Date of last: Physical Exam_____Spinal X-Ray_____Blood Test_____
Spinal Exam_____Chest X-Ray_____Urine Test_____
MRI, CT-Scan, Bone Scan_____

How many children do you have? _____ FEMALES: If you have children, how many have you had by vaginal delivery? _____ How many By C-Section?_____
Have you had any epidurals for delivery?_____ ☐ Yes ☐ No If Yes, how many times?_____

If Applicable – date of last menstrual period: _____

Do you drink ☐ Coffee (how many cups per day? _____) ☐ Tea (how many cups for day? _____)
☐ Alcohol (how many ounces per day?_____)

Do you use ☐ Cigarettes (how many per day?_____) ☐ Sugar (how many ounces per day?_____)
☐ Recreational Drugs? ☐ Artificial sweeteners?_____

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

☐ pneumonia	☐ Have Now	☐ Had in the Past	☐ depressions	☐ Have Now	☐ Had in the Past
☐ pleurisy	☐ Have Now	☐ Had in the Past	☐ arthritis	☐ Have Now	☐ Had in the Past
☐ epilepsy	☐ Have Now	☐ Had in the Past	☐ rheumatic fever	☐ Have Now	☐ Had in the Past
☐ eczema	☐ Have Now	☐ Had in the Past	☐ thyroid disease	☐ Have Now	☐ Had in thePast
☐ colitis	☐ Have Now	☐ Had in the Past	☐ whooping cough	☐ Have Now	☐ Had in the Past
☐ mumps	☐ Have Now	☐ Had in the Past	☐ heart disease	☐ Have Now	☐ Had in the Past
☐ polio	☐ Have Now	☐ Had in the Past	☐ smallpox	☐ Have Now	☐ Had in the Past
☐ cancer	☐ Have Now	☐ Had in the Past	☐ diabetes	☐ Have Now	☐ Had in the Past
☐ measles	☐ Have Now	☐ Had in the Past	☐ anemia	☐ Have Now	☐ Had in the Past
☐ stroke	☐ Have Now	☐ Had in the Past	☐ rashes	☐ Have Now	☐ Had in the Past
☐ influenza	☐ Have Now	☐ Had in the Past	☐ allergies _____	☐ Have Now	☐ Had in the Past
☐ chicken pox	☐ Have Now	☐ Had in the Past			
☐ neck pain	☐ Have Now	☐ Had in the Past	☐ low back pain	☐ Have Now	☐ Had in the Past
☐ headache	☐ Have Now	☐ Had in the Past	☐ migraines	☐ Have Now	☐ Had in the Past
☐ arm pain	☐ Have Now	☐ Had in the Past	☐ arm tingling	☐ Have Now	☐ Had in the Past
☐ shoulder pain	☐ Have Now	☐ Had in the Past	☐ hand pain/tingling	☐ Have Now	☐ Had in the Past
☐ leg pain	☐ Have Now	☐ Had in the Past	☐ leg tingling	☐ Have Now	☐ Had in the Past
☐ jaw pain	☐ Have Now	☐ Had in the Past	☐ chest pain	☐ Have Now	☐ Had in the Past
☐ lung problem	☐ Have Now	☐ Had in the Past	☐ heart problems	☐ Have Now	☐ Had in the Past
☐ ankle swelling	☐ Have Now	☐ Had in the Past	☐ blood pressure issues	☐ Have Now	☐ Had in the Past
☐ blurry vision	☐ Have Now	☐ Had in the Past	☐ irregular heartbeat	☐ Have Now	☐ Had in the Past
☐ vision probs	☐ Have Now	☐ Had in the Past	☐ cold extremities	☐ Have Now	☐ Had in the Past
☐ stuffy nose	☐ Have Now	☐ Had in the Past	☐ difficulty breathing	☐ Have Now	☐ Had in the Past
☐ fainting	☐ Have Now	☐ Had in the Past	☐ weight loss	☐ Have Now	☐ Had in the Past
☐ poor appetite	☐ Have Now	☐ Had in the Past	☐ excessive appetite	☐ Have Now	☐ Had in the Past
☐ nervousness	☐ Have Now	☐ Had in the Past	☐ confusion	☐ Have Now	☐ Had in the Past
☐ depression	☐ Have Now	☐ Had in the Past	☐ dental problems	☐ Have Now	☐ Had in the Past
☐ exces. thirst	☐ Have Now	☐ Had in the Past	☐ frequent nausea	☐ Have Now	☐ Had in the Past
☐ heartburn	☐ Have Now	☐ Had in the Past	☐ discolored urine	☐ Have Now	☐ Had in the Past
☐ irritable bowel	☐ Have Now	☐ Had in the Past	☐ black/bloody stool	☐ Have Now	☐ Had in the Past
☐ constipation	☐ Have Now	☐ Had in the Past	☐ hemorrhoids	☐ Have Now	☐ Had in the Past
☐ liver problems	☐ Have Now	☐ Had in the Past	☐ paralysis	☐ Have Now	☐ Had in the Past
☐ numbness	☐ Have Now	☐ Had in the Past	☐ fatigue	☐ Have Now	☐ Had in the Past
☐ dizziness	☐ Have Now	☐ Had in the Past	☐ loss of sleep	☐ Have Now	☐ Had in the Past
☐ hearing issue	☐ Have Now	☐ Had in the Past	☐ ear pain	☐ Have Now	☐ Had in the Past

Past injuries can affect present health – please check all that apply to you:

☐ falls/accidents	☐ Have Now	☐ Had in the Past	☐ sports injuries	☐ Have Now	☐Had in the Past
☐ auto accidents	☐ Have Now	☐ Had in the Past	☐ spinal tap	☐ Have Now	☐ Had in the Past
☐ use(d) cane	☐ Have Now	☐ Had in the Past	☐ head injuries	☐ Have Now	☐ Had in the Past
☐ broken bones	☐ Have Now	☐ Had in the Past	☐ surgery	☐ Have Now	☐ Had in the Past
☐ traction	☐ Have Now	☐ Had in the Past	☐ dislocations	☐ Have Now	☐ Had in the Past

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

_____

_____

_____

_____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed as outlined.

I hereby authorize Kennedy Chiropractic/Dr. Shawn P. Neville to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to Kennedy Chiropractic/Dr. Shawn P. Neville of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to me or Kennedy Chiropractic/Dr. Shawn P. Neville based in whole or in part upon the charges made for services received. I hereby appoint Kennedy Chiropractic/Dr. Shawn P. Neville authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Kennedy Chiropractic/Dr. Shawn P. Neville.

In order to file your claims in a timely manner, we need current and accurate insurance information for you and your dependents. We will do our best to confirm eligibility and level of insurance coverage for care; however, it is ultimately YOUR responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not. Should your insurance carrier determine that any or all of our services are inelgibile for payment, you will be billed directly for those services. Late payment for non-coverage, deductible and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.

Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier.

If you have any questions, ask.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Kennedy Chiropractic to treat my condition as deemed appropriate. At Kennedy Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Kennedy Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____

KENNEDY CHIROPRACTIC

Shawn P. Neville, DC

DOCTOR'S LIEN

PATIENT NAME: _____ ID#: _____

I hereby authorize and direct you, my attorney/insurance company to pay directly to Dr. Shawn P. Neville/Kennedy Chiropractic such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney/ insurance company, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may recover said fee.

I fully understand that if I fail to pay the full amount of these claims legal action will be taken to collect the fees owed this office. I fully understand that if this office has to resort to legal action that I will also become responsible to this office for any and all collection fees that are incurred to obtain payment.

_____ _____

Patient's Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

_____ _____

Attorney Signature Date

4140 Crain Highway
Waldorf, MD 20603

301.645.7770 Voice
301.705.8884 Fax

drshawnneville@gmail.com
www.chiropractorwaldorfmd.com

Optimal Health....through Chiropractic

PATIENT NAME: _____

Date of Accident: _____

YOUR Car Insurance Information:

Company: _____
(This is the company you must file your PIP Application with whether you were at fault or not)

Phone Number: _____ **Claim #:** _____

Name of your adjuster: _____

Insurance Information for vehicle that hit you:

Company: _____

Phone Number: _____ **Claim #:** _____

Name of adjuster: _____

ATTORNEY INFORMATION:

Name of your attorney: _____

Address: _____

_____

Phone: _____ **Fax:** _____

KENNEDY CHIROPRACTIC

Dr. Shawn P. Neville

4140 Crain Highway | Waldorf MD 20603

Phone: 301.645.7770 | Fax: 301.705.8884 |drshawnneville@gmail.com | www.drneville.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Name: Kennedy Chiropractic – Dr. Shawn P. Neville .

Address: 4140 Crain Highway City: Waldorf State: MD Zip Code: 20603

Phone: 301.645.7770 Fax: 301.705.8884 e-Mail: drshawnneville@gmail.com

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization will expire on _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient_____ Date: _____

Witness _____ Date: _____

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chiropractic

Bringing Out The Best In You!

Accident/Injury Report

Patient_____Date_____

An accident or trauma of any kind can cause you to have subluxations which can affect your physical and emotional health. Every accident victim needs a checkup by a doctor of chiropractic.

Please indicate the type of accident you were involved in:

❍ work ❍ sports ❍ auto ❍ personal injury ❍ other _____

Date of accident_____Time_____Location_____

Please explain how you were injured. Be as detailed as possible. If it was an auto accident, please mention the speed of the vehicles, where your car was hit, the damage that was done, the weather conditions and your state of mind/health at the time of the accident. Let us know if you need more paper.

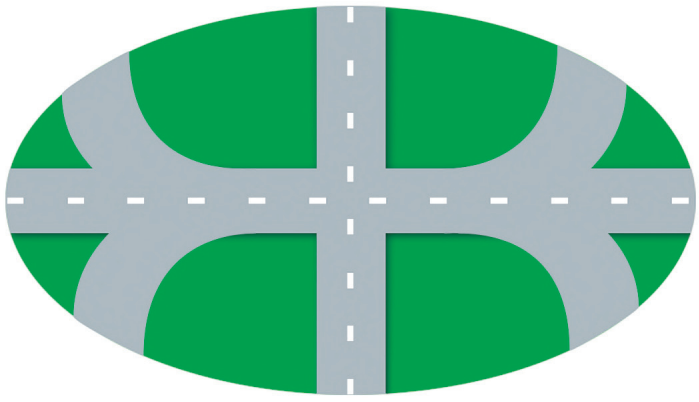
_____

_____

_____

_____

Please illustrate the accident with all involved vehicles (if applicable) below.



I was ❍ driving ❍ a passenger in a _____ on a
(type of vehicle)

_____. The other vehicle was a _____ .
(i.e., street or highway) (type of vehicle)

I was
❍ in front, left ❍ in front, right ❍ in back, left ❍ in back, right
❍ turned to the left ❍ turned to the right ❍ facing front ❍ facing back
❍ wearing a seat belt ❍ air bag deployed ❍ struck steering wheel ❍ struck headrest
❍ struck windshield ❍ other _____

Were other people in the car? ❍ no ❍ yes

If yes, were they hurt? ❍ no ❍ yes

Where were you taken after the accident and who cared for you? _____

_____

_____

Were X-rays, MRI or other tests done? ❍ no ❍ yes

If yes, please list _____

_____

What treatment was given? _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please give name(s), specialty and contact information _____

_____

_____

Injuries From The Accident

As a result of your accident, did you have any of the following (please check ✓ all that apply)

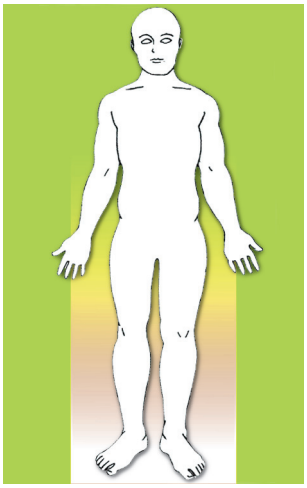
❍ broken bones ❍ dislocations ❍ head injuries ❍ surgery ❍ concussion

If yes to any of the above, please describe. _____

_____

Were you knocked unconscious? ❍ no ❍ yes If yes, for how long? _____

Please use the illustrations below to show where you are experiencing symptoms.



❍ Front _____

_____

_____

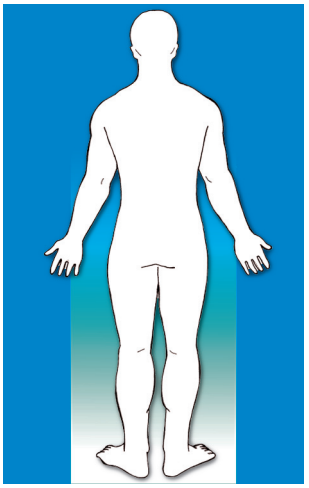
_____

❍ Back _____

_____

_____

_____



As a result of this accident, do you have any of the following (please check ✓ all that apply)

❍ dizziness
❍ memory loss
❍ tension
❍ upset stomach
❍ back stiffness
❍ headache
❍ irritability
❍ chest pain
❍ stiff neck
❍ nausea
❍ numb feet/toes
❍ blurred vision
❍ neck pain
❍ jaw problems
❍ back pain
❍ leg pain
❍ buzzing/ringing in ear
❍ disturbed sleep
❍ arm/shoulder pain
❍ numb hands/fingers
❍ shortness of breath
❍ forgetfulness
❍ fatigue
❍ other _____

Is there anything else you would like us to know? _____

_____

_____