U-MED PAIN MANAGEMENT
Dr. John P. Shannon, Jr.
Advanced Chiropractic Physician
907-561-1323

PATIENT INFORMATION

Name:_____Date of birth :_____/_____/_____Sex ☐ M ☐ F

Address:_____City:_____State:_____Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated E-Mail: _____

Home: (_____)_____ Cell: (_____)_____Work: (_____)_____

Employer:_____Phone: (_____)_____Occupation: _____

Emergency Contact:_____Phone: (_____)_____Relationship:_____

May We Contact Your PCP, if needed? Yes No

Primary Care Physician:_____Phone: (_____)_____-_____

PCP's Office Name:_____City:_____State:_____Zip:_____

Have you ever had Chiropractic Care? ☐ Yes ☐ No If Yes, how long ago? _____

Have you ever had Physical Therapy? ☐ Yes ☐ No If Yes, how long ago? _____

Is your visit related to an Auto Accident? ☐ Yes ☐ No Is your visit related to a Work Related Accident? ☐ Yes ☐ No

Have you had a Job Disability in the last 12 months? ☐ Yes ☐ No Do you have Health Insurance? ☐ Yes ☐ No

Who referred you to the office? _____

Do you exercise? ☐ Yes ☐ No If Yes, how often?_____Type? _____

Have you ever had surgery? Yes No If Yes, what surgery and when?

1. Surgery_____ Date_____/_____/_____
2. Surgery_____ Date_____/_____/_____
3. Surgery_____ Date_____/_____/_____

Medications prescribed for you / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Signature:_____Date:_____Account# :_____

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HISTORY OF PRESENT PROBLEM

Chief complaint #1:_____ When did it start: _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

What makes this complaint worse: _____

What makes this complaint better: _____

Chief complaint #2:_____ When did it start: _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

What makes this complaint worse: _____

What makes this complaint better: _____

Chief complaint #3:_____ When did it start: _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

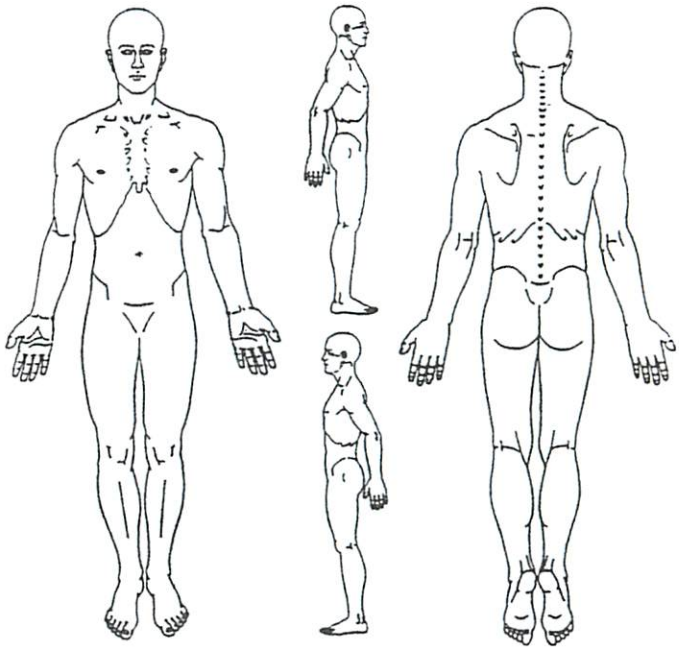
10	20	30	40	50	60	70	80	90	100

What makes this complaint worse: _____

What makes this complaint better: _____

On the diagram to the right, please indicate where you are experiencing your chief complaint by placing the letter(s) on the left on that specific area.

A: Ache **D:** Dull **R:** Throbbing **T:** Tingling
B: Burning **F:** Stiffness **S:** Soreness **Z:** Stabbing
C: Cramping **N:** Numbness **X:** Sharp **PP:** Pin Prick



Mark all activities affected by your chief complaint (s)

☐ Standing ☐ Sitting ☐ Walking ☐ Running

☐ Bending ☐ Twisting ☐ Sleeping ☐ Driving

☐ Carrying objects ☐ Lifting objects ☐ Lifting children

☐ Kneeling ☐ Exercising ☐ Housework

☐ Personal Grooming

☐ Other : _____

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Have you been treated previously for any of your condition(s)? ☐ Yes ☐ No Which one(s)? ☐ 1 ☐ 2 ☐ 3

Prior treatments for your chief complaint include: ☐ Chiropractic ☐ Physical Therapy ☐ Medical Doctor / Orthopedic

☐ Hospitalization ☐ Anti-Inflammatory ☐ Pain Medication ☐ Injection ☐ Heat/Ice ☐ Exercise ☐ Massage

☐ Other (please list) : _____

Have you ever lost work due to your condition(s)? ☐ Yes ☐ No If Yes, dates? _____

Are you, or could you be, pregnant? ☐ Yes ☐ No What was the first day of your last menstrual cycle? _____

MEDICAL HISTORY (please check all that apply) ☐ None apply

☐ Abdominal bleeding	☐ Constipation	☐ Heart disease	☐ Paralysis
☐ Allergies	☐ Convulsion	☐ Heart murmur	☐ Phlebitis
☐ Anemia	☐ Cough	☐ Hepatitis	☐ Pleurisy
☐ Arthritis	☐ Depression	☐ Hoarseness	☐ Pneumonia
☐ Asthma	☐ Diabetes	☐ High blood pressure	☐ Pus in urine
☐ Emphysema	☐ Diarrhea	☐ Indigestion	☐ Rheumatic fever
☐ Back pain	☐ Difficulty swallowing	☐ Irregular heart beat	☐ Shortness of breath
☐ Spinal disorders	☐ Dizziness	☐ Kidney infection	☐ Stroke
☐ Black tarry stool	☐ Double vision	☐ Kidney stone	☐ Swelling of feet
☐ Bleeding stool	☐ Enlarged heart	☐ Leg pain	☐ Swollen or painful joints
☐ Blood in urine	☐ Epilepsy	☐ Lung disease	☐ T.B.
☐ Bleeding disease	☐ Fainting spells	☐ Lyme disease	☐ Thyroid disease
☐ Cancer (please explain below)	☐ Gallstones	☐ Nocturia	☐ Ulcer
☐ Change in bowel habits	☐ Gall bladder disorder	☐ Nosebleeds	☐ Venereal disorders
☐ Chest pain	☐ Glaucoma	☐ Nervous disorder	☐ Vomited blood
☐ Colitis	☐ Headaches	☐ Painful urination	☐ Other (Explain below)

Explanation: _____

Please let us know the level of desire you have in truly addressing the health concerns that you have indicated above. We pledge to fully investigate your conditions to our fullest ability and with that information, develop the most efficient means of treatment possible. So, in the event we believe it is within our scope and ability to help you once we fully understand your condition, please indicate to us what your level of commitment would be to correcting your condition(s)?

1	2	3	4	5	6	7	8	9	10

Low **Medium** **High**

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the (name of yourinsurance company)_____to pay by check made out and directly mailed to:

UMED PAIN MANAGEMENT
4050 Lake Otis PKWY # 101
Anchorage, AK 99508

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

UMED PAIN MANAGEMENT
4050 Lake Otis PKWY #101
Anchorage, AK 99508

for the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

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INSURANCE SUBSCRIBER ACKNOWLEDGEMENT FORM

UMED Pain Management continues to provide as many options for insurance coverage as possible. Unfortunately, it is not feasible to be in-network with all insurance providers. This does not affect your care. As a courtesy, we submit all claims to your insurance carrier for processing. However, in the situation of non-network coverage and/if the insurance company DOES NOT send reimbursement for services to the provider, the payments will be sent directly to you, the patient and/or subscriber. UMED Pain Management will receive notification of payment status. In an effort to continue to provide you with the best care we can, we ask that you agree to the following:

(Initial the following statements in acknowledgment of your understanding and cooperation of each statement):

_____ Any correspondence with your individual insurance provider that relates to services performed by UMED Pain Management should be brought to the office immediately so that we may reconcile your account. This correspondence may include, but are not limited to, Explanation of Benefits (EOB), checks/payments, denial of benefits letters, or requests for more information.

_____ If the documentation for your claim is not provided to our office, or in the event that you happen to cash the checks that are for services provided by UMED Pain Management, you will be responsible for the entire balance of the claim.

If you have any questions about this information, please feel free to sit down with a member of the staff and discuss how we may clarify and answer your questions.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED PLEASE REVIEW IT CAREFULLY.

UMED Pain Management is committed to maintaining the privacy of your Protected Health Information known as PHI, which is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, the Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to pro- vide our patients with notice of our legal duties-and privacy practices with respect to your protected health informa- tion.

Disclosure of Your Health Care Information

Treatment : We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment : We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation : We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Public Health : As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Additional Uses and Disclosures
Law Enforcement, National Security, Funeral Director, Organ Donation, Research, Public Safety.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery,
- upon your request.
  You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation-of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by UMED Pain Management.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Dr. Robert Kuchel, compliance officer, by calling this office at 907-522-7466

Complaints
Complaints about your Privacy rights, or how UMED Pain Management has handled your health information should be directed to Dr. Robert Kuchel, compliance officer, by calling this office at 907-522-7466 . If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the appropriate Civil Rights office of Alaska.

This notice is effective as of January 1st, 2016. I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print): _____

Patient Signature:_____Date: _____