Towle Chiropractic

Non-Covered Services

Our offices provide several non-chiropractic, non-covered services. While there is research to show that these services benefit your health, many insurance companies no longer reimburse for them.

The following services may have a small fee, as of June 1, 2022, if your insurance has decided to not reimburse for them: heat/stim $5, decompression $10, rock tape $5, laser therapy $10. These services are not offered as stand-alone options at this time. They are only offered on the day of receiving a chiropractic adjustment.

PATIENT ACKNOWLEDGEMENT:

By signing below, I acknowledge that I understand that non-covered services I receive are my financial responsibility, and I am opting in to receive this care.

_____

PATIENT PRINTED NAME

_____

PATIENT SIGNED NAME

_____

DATE

Towle Chiropractic
Dr. Jamie Towle and Dr. Lisa Francey
16 Park Street Canton, NY 13617 315-386-2273

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Patient Printed Name_____ **Patients Signature** _____ **Date** _____

Dr Jamie Towle _____ **Dr. Lisa Francey Towle**_____

Towle Chiropractic Dr Lisa M Francey Towle and Dr Jamie J Towle 16 Park Street Canton, NY 13617 315-386-2273

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE Today's Date: ____ /____/____

WELCOME TO OUR OFFICE: The doctors and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*)_____(*Middle*)_____(*Last*)_____(*Prefer to be called*)_____
Address: _____City: _____ State: _____ Zip: _____
Birth Date: ____ /____/____ Age:___ Marital Status (*Circle*): Divorced Married Single Separated Widow
Gender (*Circle*): Male / Female Home Phone: (____)____-_____ Cell Phone: (____)____-_____
Social Security #: _____-_____-_____ Email Address: _____@_____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? ☐ **Yes** ☐ **No**
Referred by ☐Provider ☐Friend ☐Family ☐Other Please name_____

Employer /Employment Status ☐Employed ☐Unemployed ☐Full Time / ☐Part Time Student ☐Other
Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (____) _____-_____ Type of Work:_____
Is it ok to contact you at work? ☐ Yes ☐ No

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to a car accident or on the job injury? ☐ Yes ☐ No
Who besides yourself is responsible for your bill? ☐Self-Pay ☐Health Insurance ☐Medicare ☐Medicaid ☐Worker's Comp ☐Auto Insurance ☐ Other (*Be Specific*): _____
Health Insurance Carrier: _____ Health ID Card #:_____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ /_____/_____
Insured Person's Social Security #: _____-_____-_____
Auto or Workers' Comp Insurance Carrier & Claim #: _____

Emergency Contact Information
Name: (*First*)_____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to Towle Chiropractic for services rendered to me.

Patient Initials_____

OBLIGATION OF PAYMENT:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information
gathering so that the doctor can determine whether to accept me as a patient.

ACKNOWLEDGEMENT OF MAINTENANCE/ELECTIVE CARE:

You are financially responsible for all non-covered services. You may choose to receive maintenance care that your insurance company does not deem medically necessary.

INFORMED CONSENT:

The doctors will use their hands or devices in order to move your joints. They may also use various ancillary procedures such as hot or cold packs, electric muscle stimulation, cold laser, or spinal decompression. You may feel a "click" or a "pop". Complications are described as "rare". Possible risks include fracture, strain, injury to discs or nerves. There are also risks associated with not receiving chiropractic care such as formation of adhesions and decrease in mobility.

HIPPA COMPLIANCE:

This office will protect your sensitive patient health information from being disclosed without your consent or knowledge. You are aware that the doctors work closely with other health care professionals with the intention of offering comprehensive care. I consent to the use and release of any portion of my information in order to diagnose, treat, care or obtain payment.

SETTING REASONABLE EXPECTATIONS:

Many patients experience some immediate relief. For others it can take weeks or months. Chiropractic care in not a "quick fix". Many factors affect the healing process. Proper spinal hygiene is not to most people, and we will do our best to explain how you can achieve better health. The better you understand your condition, and follow your prescribed treatment plan, the faster your recovery may be.

GENERAL OFFICE POLICIES:

1. Please wear loose fitting clothing that is free from sharp objects such as belts or keys. 2. All co-payments are due at the time you check in for your appointment. 3. We require 24 hours' notice for changing your appointment time. 4. Any changes to your insurance policy needs to be brought to our attention ASAP. We cannot make changes in your past, previously billed visits. Failure to notify us properly may leave you personally financially responsible for any unpaid insurance bills.

Patient Initials_____

REFERRALS:

It our great joy to serve this community. Please tell your family and friends about our office so that we can continue to promote a wellness lifestyle.

Your reason for today's visit_____

The most important thing for you right now is to be able to?_____

How did you hear about our office?_____

What types of activities do you enjoy?_____

What are you not able to do fully because of your problem?_____

What are your health goals?_____

How committed are you to achieving your goal?_____

How long do you believe it will take to get better?_____

Do you know chiropractic care is a process and not a quick fix?_____

Why do you believe chiropractic wellness care is the best choice for your condition?_____

_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

(please list)_____

_____

_____

PATIENT PRINTED NAME

_____

PATIENT SIGNATURE

_____

TODAY'S DATE

Patient Health Questionnaire- Symptom Check-Up
(Exacerbation/Re-evaluation)

Patient Name:_____ Date:_____

Answer the following questions:

1. Describe your current symptoms_____

_____

2. What was the cause of your symptoms?_____
3. What is the date the symptoms started?_____
4. What activities make your symptoms worse?_____
5. What activities make your symptoms better?_____

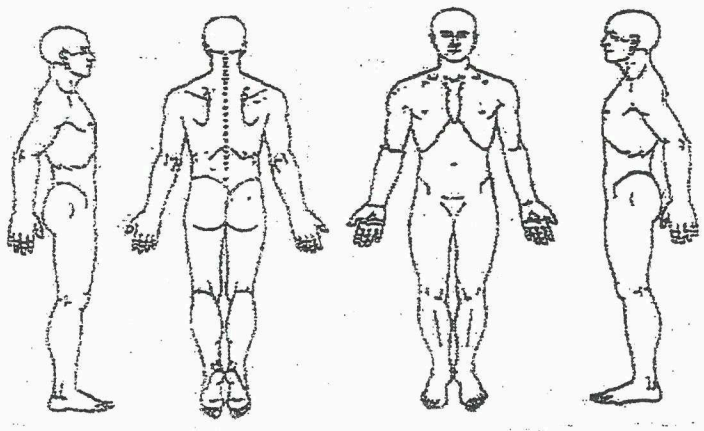
Circle best answer:

6. Is today's visit from an auto accident or worker's comp injury? Yes No
7. How often do you experience your symptoms?
   a. constantly (76%-100% of the day) c. occasionally (26-50% of the day)
   b. frequently (51-75% of the day) d. intermittently (0-25%) of the day)
8. What describes the nature of your symptoms?
   a. sharp b. dull ache c. numb d. shooting e. burning f. tingling
9. How are your symptoms changing?
   a. getting better b. not changing c. getting worse
10. Please rate the average intensity of your symptoms:
    (none) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
11. How often do your symptoms disrupt you to perform your daily activities?
    a. Not at all b. A little bit c. Some of the time d. Frequently e. Constantly

Please indicate where you have pain or other symptoms on the diagram below:

HT _____

WT_____



Patient's Signature_____

Towle Chiropractic Dr Lisa F Francey Towle and Dr Jamie J Towle 16 Park Street Canton, NY 13617 315-386-2273

REVIEW OF SYSTEMS

Patient Name: _____ Insurance _____ Today's Date:_____/_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐**None**
- ☐Chills
- ☐Daytime Drowsiness
- ☐Fatigue
- ☐Fever
- ☐Night Sweats
- ☐Weight Gain
- ☐Weight Loss

Eyes/Vision:
- ☐**None**
- ☐Blindness
- ☐Blurred Vision
- ☐Cataracts
- ☐Change in Vision
- ☐Double Vision
- ☐Eye Pain
- ☐Field Cuts
- ☐Glaucoma
- ☐Itching *(around the eyes)*
- ☐Photophobia
- ☐Tearing
- ☐Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐**None**
- ☐Bleeding
- ☐Dental Implants
- ☐Dentures
- ☐Difficulty Swallowing
- ☐Discharge
- ☐Dizziness
- ☐Ear Drainage
- ☐Ear Infection*(s)*
- ☐Ear Pain
- ☐Fainting
- ☐Headaches
- ☐Head Injury *(history of)*
- ☐Hearing Loss
- ☐Hoarseness
- ☐Loss of Smell
- ☐Nasal Congestion
- ☐Nose Bleeds
- ☐Post Nasal Drip
- ☐Rhinorrhea *(runny nose)*
- ☐Sinus Infections
- ☐Snoring
- ☐Sore Throats
- ☐Tinnitus *(ringing in the ears)*
- ☐TMJ Disorder

Cardiovascular:
- ☐**None**
- ☐Angina *(chest pain or discomfort)*
- ☐Chest Pain
- ☐Claudication *(leg pain or achiness)*
- ☐Heart Murmur
- ☐Heart Problems
- ☐Orthopnea *(difficulty breathing while lying)*
- ☐Palpitations *(irregular or forceful heart beat)*
- ☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐Shortness of Breath
- ☐Swelling of Leg*(s)*
- ☐Ulcers
- ☐Varicose Veins

Gastrointestinal:
- ☐**None**
- ☐Abdominal Pain
- ☐Belching
- ☐Black, Tarry Stools
- ☐Constipation
- ☐Diarrhea
- ☐Difficulty Swallowing
- ☐Heartburn
- ☐Hemorrhoids
- ☐Indigestion
- ☐Jaundice *(yellowing of the skin)*
- ☐Nausea
- ☐Rectal Bleeding
- ☐Abnormal Stool Caliber *(quality)*
- ☐Abnormal Stool Color
- ☐Abnormal Stool Consistency
- ☐Vomiting
- ☐Vomiting Blood

Respiration:
- ☐**None**
- ☐Asthma
- ☐Coughing up blood
- ☐Shortness of Breath
- ☐Sputum Production
- ☐Wheezing

Endocrine:
- ☐**None**
- ☐Cold Intolerance
- ☐Diabetes
- ☐Excessive Appetite
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Frequent Urination
- ☐Goiter
- ☐Hair Loss
- ☐Heat Intolerance
- ☐Unusual Hair Growth
- ☐Voice Changes

Skin:
- ☐**None**
- ☐Changes in Nail Texture
- ☐Changes in Skin Color
- ☐Hair Growth
- ☐Hair Loss
- ☐Hives
- ☐Itching
- ☐Paresthesia (numbness, prickling, or tingling)
- ☐Rash
- ☐History of Skin Disorders
- ☐Skin Lesions or Ulcers
- ☐Varicosities

Nervous System:
- ☐**None**
- ☐Dizziness
- ☐Facial Weakness
- ☐Headaches
- ☐Limb Weakness
- ☐Loss of Consciousness
- ☐Loss of Memory
- ☐Numbness
- ☐Seizures
- ☐Sleep Disturbance
- ☐Slurred Speech
- ☐Stress
- ☐Strokes
- ☐Tremors
- ☐Unsteadiness of Gait

Allergy:
- ☐**None**
- ☐Anaphylaxis *(history of)*
- ☐Food Intolerance
- ☐Itching
- ☐Nasal Congestion
- ☐Sneezing

Hematology:
- ☐**None**
- ☐Anemia
- ☐Bleeding
- ☐Blood Clotting
- ☐Blood Transfusion*(s)*
- ☐Bruises easily
- ☐Fatigue
- ☐Lymph Node Swelling

Psychological:
- ☐**None**
- ☐Anhedonia *(inability to experience joy or enjoy life)*
- ☐Anxiety
- ☐Appetite Changes
- ☐Behavioral Change*(s)*
- ☐Bipolar Disorder
- ☐Confusion
- ☐Convulsions
- ☐Depression
- ☐Insomnia
- ☐Memory Loss
- ☐Mood Change*(s)*

Female:
- ☐**None**
- ☐Birth Control Therapy
- ☐Breast Lumps / Pain
- ☐Burning Urination
- ☐Cramps
- ☐Frequent Urination
- ☐Hormone Therapy
- ☐Irregular Menstruation
- ☐Urine Retention
- ☐Vaginal Bleeding
- ☐Vaginal Discharge

Male:
- ☐**None**
- ☐Burning Urination
- ☐Erectile Dysfunction
- ☐Frequent Urination
- ☐Hesitancy or Dribbling
- ☐Prostate Problems
- ☐Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ Doctor Signature _____ Date

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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 more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score