

BEECHER CHIROPRACTIC CLINIC

1001 PINELOCH, STE 700

HOUSTON, TX. 77062

PH: (281) 286-1300 FAX: (281) 286-1339

Confidential New Patient Information For United Healthcare

The following information is needed for our files so we can better serve you as a patient. Please print and fill out all portions of this form. All information is confidential.

Patient Data:

Name: _____

Patient's Employer: _____

Address: _____

Business Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell: _____

WK Phone: _____ Occupation: _____

SSN: _____ SEX: ☐ M ☐ F

Policy Holder's Employer (If different from above): _____

Birthdate: _____ Age: _____ # Of Children: _____

WK Phone: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact _____

Referred By: _____

Relationship: _____ Phone: _____

Insurance Information: (Your Primary Medical Insurance)

Name of Insured: _____

Name of Insurance: _____

Relation to Patient: _____

Ins. Phone: _____

Birthdate: _____ SSN: _____

Group #: _____ Member #: _____

Employer: _____

Type of Insurance: ☐ PPO ☐ POS ☐ HMO ☐ Medicare ☐ Other

(Your Secondary Medical Insurance) If Any:

Name of Insurance: _____

Group #: _____ Member #: _____

Ins. Phone: _____

Type of Insurance: ☐ PPO ☐ POS ☐ HMO ☐ Medicare ☐ Other

Health History

Present Complaint:

Briefly Describe Symptoms: _____

List any/or all Doctors seen for this condition: _____

MEDICAL HISTORY: If any of the following are relevant to your medical history, please check.

☐ CANCER ☐ MUSCULAR DYSTROPHY ☐ NERVOUSNESS ☐ ASTHMA ☐ ARTHRITIS
☐ EPILEPSY ☐ MULTIPLE SCLEROSIS ☐ DIABETES ☐ CONVULSIONS ☐ SINUS TROUBLE
☐ ANEMIA ☐ OTHER IF OTHER, PLEASE LIST _____

Date of Last Physical Exam _____ Name of Doctor: _____

Describe and Date of any operations had: _____

Are you allergic to any medication: ☐ NO ☐ YES What Kind: _____

Are you taking any medication: ☐ NO ☐ YES What Kind: _____

(FEMALE PATIENTS) Are you Pregnant: ☐ NO ☐ YES Date of last menstrual period: _____

PLEASE CONTINUE ON BACK OF THIS FORM

Confidential New Patient Information For United Healthcare, Page 2

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AND INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNTS AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE CO-ISSUED REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS OFFICE HEREBY AUTHORIZE DR. WARD BEECHER (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING THERAPY AND MANIPULATION AND SUCH ADDITIONAL THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID TREATMENT. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR CHIROPRACTIC TREATMENTS, THE REASONS WHY THE ABOVE NAMED TREATMENT IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT, WHICH WERE EXPLAINED TO ME BY DR. BEECHER. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

CONSENT TO TREATMENT OF CHILD

I HEREBY AUTHORIZE DR. BEECHER AND ASSISTANTS TO ADMINISTER TREATMENT TO MY: SON OR DAUGHTER.

SIGNATURE OF LEGAL GUARDIAN

DATE

ASSIGNMENT OF RIGHTS

YOUR INSURANCE COMPANY IS INSTRUCTED TO PAY BEECHER CHIROPRACTIC CLINIC FOR ALL PROFESSIONAL SERVICES RENDERED AT THIS OFFICE. THIS INSTRUCTION TO MY INSURANCE COMPANY IS MY ASSIGNMENT OF RIGHTS UNDER MEDICAL COVERAGE TO THE EXTENT OF MY BILL. THIS INCLUDES ALL CLAIMS, BE THEY 1ST OR 3RD PARTY CLAIMS. ANY SUM OF MONEY PAID UNDER ASSIGNMENT SHALL BE CREDITED TO MY ACCOUNT AND I SHALL PERSONALLY BE LIABLE FOR ANY UNPAID BALANCES DUE TO THE DOCTOR (UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE AT TIME OF SERVICE. ALSO, I AM PERSONALLY LIABLE FOR ANY UNPAID ACCOUNTS FOR HOSPITAL, DIAGNOSTIC AND CONSULTANT SERVICES. IT IS ALSO MY UNDERSTANDING THAT MY INSURANCE COMPANY AT DATE OF SERVICE MAY BE SENDING PAYMENTS TO ME FOR SERVICES RENDERED AT BEECHER CHIROPRACTIC CLINIC. UPON THE RECEIPT OF THESE CHECKS AND REMITTANCES, I AGREE TO BRING THESE ITEMS INTO BEECHER CHIROPRACTIC CLINIC.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

HIPPA COMPLIANCE/PRIVATE PRACTICE LAWS

BY SIGNING I HEREBY STATE THAT I AM AWARE OF THE PRACTICE PRIVACY NOTICE AND THAT THE PRIVACY NOTICE IS LOCATED AT MY DISPOSAL IN THE OFFICE AND I CAN REQUEST IT FOR REVIEW AT ANY TIME. I HEREBY AGREE TO ALL GUIDELINES AS IS NECESSARY FOR THE PRACTICE TO CONDUCT ITS HEALTH CARE OPERATIONS.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

PLEASE COMPLETE THE QUESTIONNAIRE ON THE FOLLOWING PAGE.

Patient Summary Form

PSF-750 (Rev 2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

Fax number may vary by plan

Patient Information

| | | | | | | |
|-------------------------------------|--|--------------------------------------|------------------------------|---------------------------------|-------|----------|
| Patient name Last First MI | | | <input type="radio"/> Female | Patient date of birth | | |
| | | | <input type="radio"/> Male | | | |
| Patient address | | | | City | State | Zip code |
| | | | | | | |
| Patient insurance ID# | | Health plan | | Group number | | |
| | | | | | | |
| Referring physician (if applicable) | | Date referral issued (if applicable) | | Referral number (if applicable) | | |
| | | | | | | |

Provider Information

| | | | | | | | |
|---|--|--|--|--|--|-----------------|--|
| 1. Name of the billing provider or facility (as it will appear on the claim form) | | | | 2. Federal tax ID (TIN) of entity in box #1 | | | |
| Ward Beecher, DC | | | | 76-0315863 | | | |
| 3. Name and credentials of the individual performing the service(s) | | | | <input type="checkbox"/> MD/DO <input checked="" type="checkbox"/> DC <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Both PT and OT <input type="checkbox"/> Home Care <input type="checkbox"/> ATC <input type="checkbox"/> MT <input type="checkbox"/> Other | | | |
| Ward Beecher | | | | | | | |
| 4. Alternate name (if any) of entity in box #1 | | | | 5. NPI of entity in box #1 | | 6. Phone number | |
| Beecher Chiropractic Clinic | | | | 1598771073 | | 281-286-1300 | |
| 7. Address of the billing provider or facility indicated in box #1 | | | | 8. City | | 9. State | |
| 1001 Pineloch Dr. Ste. 700 | | | | Houston | | TX | |
| | | | | | | 10. Zip code | |
| | | | | | | 77060 | |

Provider Completes This Section:

Date you want THIS submission to begin:

| | | |
|--|--|--|
| | | |
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Patient Type

- ☐ New to your office
☐ Est'd. new injury
☐ Est'd. new episode
☐ Est'd. continuing care

Cause of Current Episode

- ☐ (1) Traumatic ☐ (4) Post-surgical
☐ (2) Unspecified ☐ (5) Work related
☐ (3) Repetitive ☐ (6) Motor vehicle

Date of Surgery

| | | |
|--|--|--|
| | | |
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Type of Surgery

- ☐ (1) ACL Reconstruction
☐ (2) Rotator Cuff/Labral Repair
☐ (3) Tendon Repair
☐ (4) Spinal Fusion
☐ (5) Joint Replacement
☐ (6) Other

Diagnosis (ICD code)

Please ensure all digits are entered accurately

| | | | | |
|----|--|--|--|--|
| 1° | | | | |
| 2° | | | | |
| 3° | | | | |
| 4° | | | | |

Nature of Condition

- ☐ (1) Initial onset (within last 3 months)
☐ (2) Recurrent (multiple episodes of < 3 months)
☐ (3) Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

- ☐ 98940 ☐ 98942
☐ 98941 ☐ 98943

Current Functional Measure Score

| | | | | |
|------------|--|------|--|---------|
| Neck Index | | DASH | | |
| Back Index | | LEFS | | (other) |

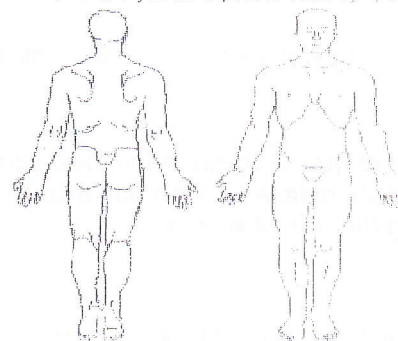
Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

| | | |
|--|--|--|
| | | |
|--|--|--|

Indicate where you have pain or other symptoms.



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

| | | | | | | | | | | | | | |
|----------------|---------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|--------------------------|------------|
| Last 24 hours: | no pain | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10 | worst pain |
| Past week: | no pain | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10 | worst pain |

4. How often do you experience your symptoms?

- ☐ (1) Constantly (76%-100% of the time) ☐ (2) Frequently (51%-75% of the time) ☐ (3) Occasionally (26% - 50% of the time) ☐ (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- ☐ (1) Not at all ☐ (2) A little bit ☐ (3) Moderately ☐ (4) Quite a bit ☐ (5) Extremely

6. How is your condition changing, since care began at this facility?

- ☐ (0) N/A — This is the initial visit ☐ (1) Much worse ☐ (2) Worse ☐ (3) A little worse ☐ (4) No change ☐ (5) A little better ☐ (6) Better ☐ (7) Much better

7. In general, would you say your overall health right now is...

- ☐ (1) Excellent ☐ (2) Very good ☐ (3) Good ☐ (4) Fair ☐ (5) Poor

Patient Signature: X

Date:

SF-12™ Health Survey

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ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ Date _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. In general, would you say your health is: ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

| | Yes, limited a lot | Yes, limited a little | No, not limited at all |
|--|--------------------|-----------------------|------------------------|
| a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? | ① | ② | ③ |
| b. Climbing several flights of stairs? | ① | ② | ③ |

3. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

| | Yes | No |
|--|-----|----|
| a. Accomplished less than you would like | ① | ② |
| b. Were limited in the kind of work or other activities | ① | ② |

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

| | Yes | No |
|---|-----|----|
| a. Accomplished less than you would like | ① | ② |
| b. Didn't do work or other activities as carefully as usual | ① | ② |

5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....

| | All of the time | Most of the time | A good bit of the time | Some of the time | A little of the time | None of the time |
|--|-----------------|------------------|------------------------|------------------|----------------------|------------------|
| a. Have you felt calm and peaceful? | ① | ② | ③ | ④ | ⑤ | ⑥ |
| b. Did you have a lot of energy? | ① | ② | ③ | ④ | ⑤ | ⑥ |
| c. Have you felt downhearted and blue? | ① | ② | ③ | ④ | ⑤ | ⑥ |

7. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

Neck Index

ACN Group, Inc. - Form NI-100

ACN Group, Inc. Use Only rev 11/13/02

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

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Neck
Index
Score

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Back Index

ACN Group, Inc. - Form BI-100

ACN Group, Inc. Use Only rev 11/13/02

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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Back
Index
Score

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