Birmingham Health
801 Shades Crest Rd, Ste B
Birmingham, AL 35226
205-385-9999

New Patient Information

Thank you for choosing our practice to assist with your healthcare needs! We strive to provide the best care possible.

Who do we have to thank for this referral? _____

Name_____ Date of Birth ___/____/_____

Address_____ City_____ State_____ ZIP_____

Phone_____ - _____ - _____ Home___ Cell ___ Work ___ Ok to leave a message?____

Phone_____ - _____ - _____ Home___ Cell ___ Work ___ Ok to leave a message?____

Email_____ @_____

Insurance Information

BCBS___

Dr. Casey is only in network with BCBS PPO. If you don't have this insurance as your primary insurance, you are asked to pay in full at the time of the visit. We will provide you with proper forms to submit to your insurance company for reimbursement.

Name of insured: _____

Date of Birth ___/____/_____ Relationship to Patient_____

Policy Number_____ Group Number_____

Emergency Contact

Name_____

Phone_____ - _____ - _____ Relationship to Patient_____

_____ **Initial**

Informed Consent to Chiropractic Treatment

The State of Alabama requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is the Birmingham Health Informed consent. We intend this consent form to cover the entire course of treatment for your present condition and for any future conditions for which you seek treatment at Birmingham Health.

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to manipulate your joints. You may hear a “click” or a “pop,” similar to when a knuckle is “cracked,” and you may feel the movement of the joint. Various ancillary procedures, soft tissue work, electrical muscle stimulation, acupuncture, therapeutic ultrasound, or traction, as well as exercise and nutrition instruction may also be used.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any healthcare provider, ranging from taking a simple aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic manipulation. The risk is very minor to almost nonexistent in any treatment of the extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the inter-vertebral discs, nerves, or spinal cord (very rare). The risk involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very, very rare; chances are one in one million to one in ten million. The literature has proven that a dissection already occurred in those cases before entering the chiropractic clinic where treatment was performed). A minority of patients may also notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

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

Over-the-counter analgesics. The risks of these medications include irritation to the 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 numerous undesirable effects, usually more serious than those listed above, and patient dependence in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death), as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows for the 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.

Privacy Notice: We will maintain the privacy of your health information. Test results will only be given to the patient or legal guardian, unless written authorization is obtained from the patient. Medical information is released to third-party payers, other health practitioners, radiology, lab, and as needed to facilitate appropriate medical treatment with each patient. We follow the guidelines of the Health Insurance Portability and Accountability Act (HIPPA).

_____ **Initial**

Concerns or questions: Please ask Dr.Casey. Dr. Casey has gone to great lengths to make your health and safety his top priority. He will be glad to explain any concern about treatment you might have. Suffice it to say he will only recommend treatment for you that he would feel comfortable having performed on himself. I have read the above explanation of chiropractic treatment. I also had the opportunity to ask questions and have them 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 hereby give my full consent to treatment.

Printed Name of Patient _____

Patient Signature_____ Date_____

(Parent Signature if Patient is a Minor)

For Minors

I, _____. have been informed of the risks, benefits, and alternatives to care. I am authorizing Dr. Casey to treat _____.

Signature _____ Date _____

Relationship to Patient_____

_____ **Initial**

Office Policies

Thank you for choosing our practice for you health care needs. We integrate conventional medicine and integrative medicine to provide the best healthcare possible. Dr. Casey is a board certified chiropractic physician. He is also certified in acupuncture.

Our practice is ever mindful of trying to keep healthcare costs down in order to help our patients. We do recommend that you continue care with you current primary care provider (PCP). If you don't have one, we would be happy to recommend. Due to Alabama state law Dr. Casey is not able write or prescribe medications. Because of this we are not a PCP provider. We will work with and notify your PCP if and when necessary.

Insurance

BCBS.
As a courtesy to our patients, we are contracted with Blue Cross Blue Shield PPO. For those patients with BCBS we will submit claims for you. All outstanding balances after insurance settlement will be charged to the given credit card. Please see the Financial Policy for further details. As a patient, it is your responsibility to know what is/is not covered by your insurance company.

Medicare
Please note that Medicare only covers spinal adjustments. All other services, including exams, x-rays, extremity adjustments, IFC, soft tissue work, ultrasound, and acupuncture are not covered and will need to be paid at the time of the visit.

Other Insurance Companies
We see many patients with other insurances as an out-of-network provider. In these cases, payment in full is required at the time of the visit, and we will provide a superbill to you so you can send it to your insurance company for reimbursement purposes. As a patient, it is your responsibility to know what is.is not covered by your insurance company.

Appointments
Since Dr. Casey practices chiropractic, acupuncture, body-work, and nutrition, we may require separate visits due to time constraints. If your visit is greater than 40-45 minutes, and there are complicated health problems, we often add a prolonged visit code and/or an additional medical code. This may or may not be covered by your insurance. We realize your time is valuable, and you may need to appropriately charge for the doctor's time.

Coding of Visits
In general, we will not re-code patients visits after the visit has been submitted to your insurance company.

Canceling an Appointment
Should you need to cancel an appointment, please give our office 24 hours notice. Any appointment cancelled with less than the 24-hour notice is subject to a $25 cancellation fee, which will be billed to the credit card on file.

Telephone Calls
Our staff may handle brief questions, but in-depth questions will require an appointment with the doctor.

_____ **Initial**

Patient Balances
Patients are required to have an updated credit card on file. After we receive your EOB, we will charge your credit card. If, for any reason, your card on file cannot be charged, a 3% monthly fee will be added until your account is paid in full.

Acupuncture
Acupuncture is often not a covered service by insurance. The cost is due at the time of visit.

Acknowledgement
By signing below, you acknowledge that you have read, understood, and will abide by policies and procedure of Birmingham Health.

Accepting Assignment to Your Case

This office is pleased to accept your case on assignment. It is your responsibility to know your insurance benefit coverage. We will file your claim forms to assist you in every way we can for reimbursement from plans that we are in-network provider. We must make it clear that insurance contracts are between you, the patient, and your insurance company. You are responsible for any amount not paid by your insurance company/or paid directly to you from the insurance company. By accepting your insurance on assignment, we are extending credit to you. This courtesy may be withdrawn if circumstances below warrant. It is imperative that you understand these conditions and agree to them: Your insurance should pay within 30 days of your office visit. If you insurance has not paid within 60 days, then you will be responsible to pay the balance due. You will be reimbursed by our office when your insurance company pays the outstanding balance.

1. We will continue to bill your insurance as long as you are receiving active care in our office.
2. We require a valid credit card be kept on file with your account. This card will be charged in the event you are required to pay a coinsurance/deductible/additional copay per your policy.
3. Deductibles must be satisfied prior to assignment being enacted.
4. Copayment will be collected at time of service.
5. You are required to sign the informed consent, medical release forms, as wells as any other assignment documents required by your insurance company.
6. Our office does not guarantee that your insurance company will pay. If, for any reason, your insurance claim is denied, you are responsible for the full amount of your balance. Any past due accounts are subject to a 3% monthly fee after 90 days. If an account is six months past due, it will be sent to collections.
7. Our office will not enter into a dispute with your insurance company over any claim. This is ultimately your responsibility and obligation.
8. Returned checks are subject to a $50.00 fee.

If you understand and agree with all of the above policies, please sign your name below, and we will accept your insurance assignment as stated above.

Name_____ Date _____

_____ **Initial**

Privacy Rights Verification

As required by federal regulations, I have been given the opportunity to read the Notice of Private Practices.

I designate the following family members and/or friends as eligible to share my protected health information. Information will not be shared with Persons NOT Listed on this form.

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that permission to release my health information to the family members and/or friends listed on this form is for a period of one (1) year, and that I may renew the permission at the end of one (1) year. I also understand that I may revoke permission to share my health information with a family member or friend, at any time, by submitting a request, in writing, to Ideal Health & Wellness.

Check here _____ and initial ( ) if you do not want to designate someone with access to your medical information.

Name_____ Date _____

_____ **Initial**

Card Authorization

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card. The card is then imprinted and later used to pay your bills. This is an advantage for both you and the hotel/rental company since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at your first appointment and when it needs to be updated. Your credit information will be held securely. After your insurances have paid their portion and notified us regarding the amount you owe, any remaining balance will be charged to your credit card and a receipt will be mailed to you. This applies to balances for office visits, labs, and other services.

This will be an advantage to you since you will no longer have to write and mail checks to us. It will be an advantage to us as well, since it will greatly decrease the number of statements that must be generated and sent. The combination will benefit everyone in helping to keep the cost of healthcare down. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Copays are still due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask.

The fee for a returned check is $50.00. This fee will automatically be charged to your account when your check is returned from the bank. If all payments are not received by this office within 90 days, you will be unable to schedule further appointments until all outstanding monies are received. Any account balance past 90 days will be assessed 3% fee per month until account is paid in full. After six months, your account will be sent to collections.

Please note: If your insurance sends checks to you instead of our practice, you are responsible for the balance. Please sign the insurance check over to Dr. Alex Casey. Bring the check and your EOB (Explanation of Benefits), and we will credit your account accordingly. Please note- failure to do so, constitutes insurance fraud and will be reported.

Name of Credit Card Holder:_____

Signature of Credit Card Holder:_____

Name of Spouse/Dependents who will also be able to use this card for billing:

Circle One: Visa MasterCard Discover

Credit Card Number ___ ___ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ___ ___

Verification Code (on back of card): ____ ____ ____ Expiration Date: _____ / _____

Billing Zip Code: _____

Name_____ Date _____

_____ **Initial**

Health History

Please describe the main problem(s) that brings you in today:

_____

_____

Describe your symptoms:

- ❑ Aching
- ❑ Burning
- ❑ Dull Pain
- ❑ Sharp Pain
- ❑ Stabbing Pain
- ❑ Throbbing
- ❑ Stiffness
- ❑ Weakness
- ❑ Numbness/Tingling
- ❑ Functional Changes
- ❑ Loss of Range of Motion
- ❑ Other: _____

On a scale of 0-10, how would you rate your pain right now? ____ On average? ____ At its best?____
At its worst? ____

Are your symptoms related to an accident or specific injury? Y/N (If yes, please describe)
_____

When did your symptoms begin? _____

Did your symptoms come on gradually? Y/N

Have you had this problem before? Y/N (If yes, please describe)
_____

Did it previously get better? Y/N How? _____

What is the frequency of your symptoms?

- ❑ Constant
- ❑ Frequent ____ x/day
- ❑ Intermittent ____ x/week
- ❑ Occasional

How are your symptoms progressing? ____ Improving ____Worsening ____Staying the same
Are you able to continue working? ____ Yes, full duty ____ Yes, light duty ____ No, as of _____

Do you have periods of time when you are completely symptom free? Y/N

Do your symptoms awaken you at night? Y/N (if yes, how many times?) ____/night

What makes your symptoms better?

- ❑ Ice
- ❑ Heat
- ❑ Exercise
- ❑ Lying Down
- ❑ Postural Changes
- ❑ Rest
- ❑ Stretching
- ❑ Support Brace
- ❑ Standing
- ❑ Walking
- ❑ Medication _____
- ❑ Other _____

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What makes your symptoms worse?

- ❑ Activity _____
- ❑ Bending
- ❑ Lifting
- ❑ Standing for _____ mins/hours
- ❑ Stress
- ❑ Temperature Changes
- ❑ Twisting
- ❑ Climbing Stairs
- ❑ Kneeling
- ❑ Reaching
- ❑ Sitting for _____ mins/hours
- ❑ Walking

Have you experienced any of the following with your current problem?

- ❑ Buckling
- ❑ Loss of balance
- ❑ Pain with coughing/sneezing
- ❑ Lip numbness
- ❑ Locking
- ❑ Dislocating
- ❑ Giving Way
- ❑ Dizziness/blurred vision
- ❑ Numbness around groin
- ❑ Hearing issues
- ❑ Unconsciousness
- ❑ Nauseousness

Social/Health Information:
Do you currently smoke? Y/N (if yes, how much?) _____ amount
Have you smoked in the past? Y/N (if yes, when did you quit?) _____
Do you exercise regularly? Y/N
How many times per week? _____ How long for? _____
Please describe your exercise _____

Medical/Surgical History:

- ❑ Arthritis
- ❑ Blood Disorder
- ❑ High Blood Pressure
- ❑ Diabetes/High Blood Sugar
- ❑ Head Injury
- ❑ Muscular Dystrophy
- ❑ Allergies
- ❑ Cancer
- ❑ Repeated Infections
- ❑ Multiple Sclerosis
- ❑ Seizures/Epilepsy
- ❑ Developmental/Growth Problems
- ❑ Infectious Disease (HIV, TB, HepC)
- ❑ Skin Disorders
- ❑ Broken Bones/Fractures
- ❑ Circulation/Vascular Disorder
- ❑ Numbness around groin
- ❑ Lung Problems
- ❑ Anxiety/Depression
- ❑ Parkinson's Disease
- ❑ Thyroid Conditions
- ❑ Kidney Problems
- ❑ Ulcer/Stomach Problems
- ❑ Osteopenia/Osteoporosis
- ❑ Heart Problems
- ❑ Stroke
- ❑ Low Blood Pressure/Hypoglycemia

Have you ever had surgery? Y/N (If yes, please describe area and date)
_____
_____

List all prescribed and non-prescribed medications you are currently taking
_____
_____
_____

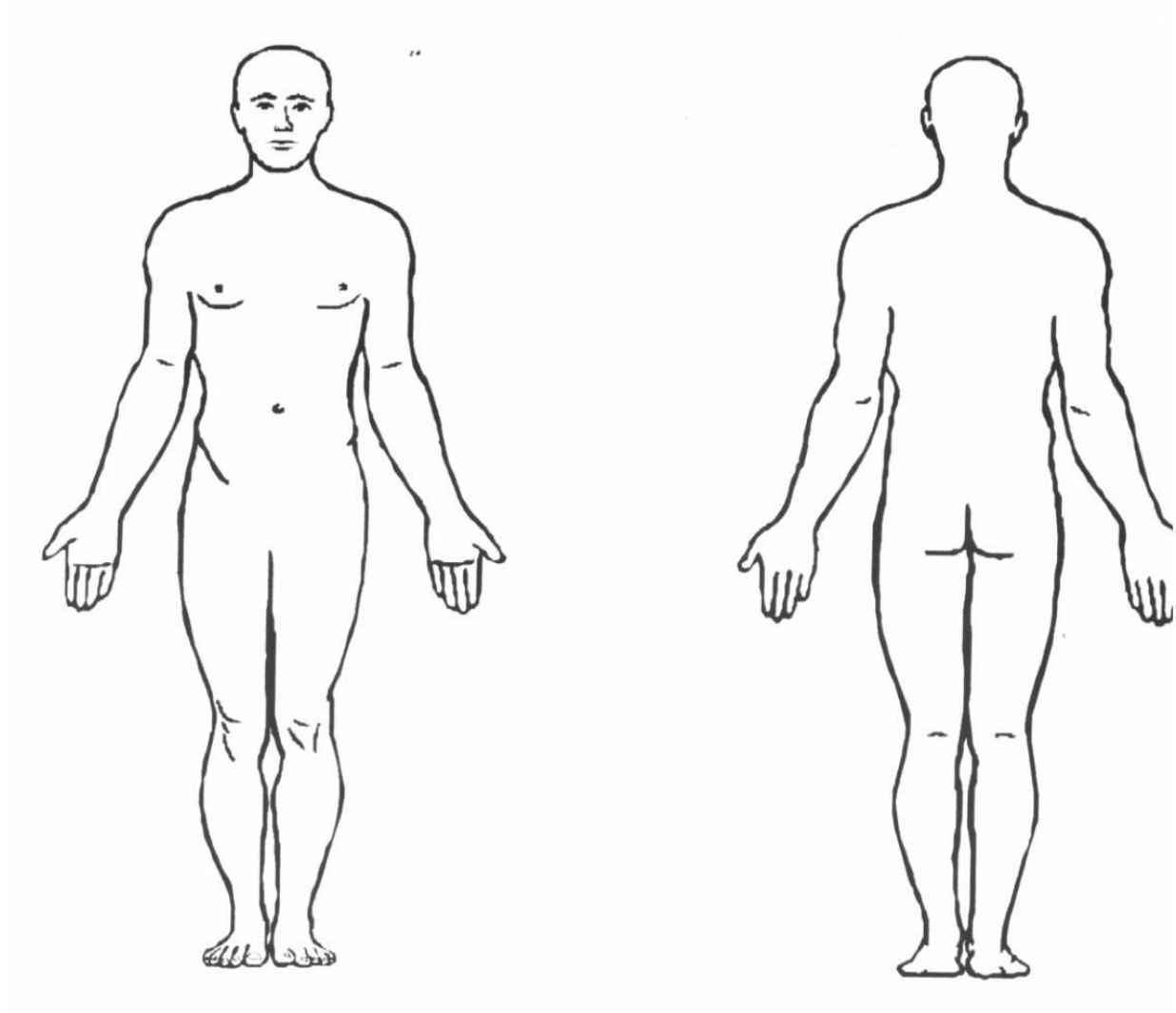
_____ **Initial**

Within the past year, have you had any of the following symptoms?

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ High Blood Pressure
- ❑ Loss of Balance
- ❑ Joint Pain/Swelling
- ❑ Loss of Appetite
- ❑ Weight Loss/Gain
- ❑ Hearing Changes
- ❑ Heart Palpitations
- ❑ Dizziness or Blackouts
- ❑ Bowel Problems
- ❑ Difficulty Walking
- ❑ Pain At Night
- ❑ Nausea/Vomiting
- ❑ Urinary Problems
- ❑ Vision Changes
- ❑ Unexplained Cough
- ❑ Coordination Problems
- ❑ Weakness in Arms or Legs
- ❑ Difficulty Sleeping
- ❑ Headaches
- ❑ Numbness/Tingling

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark the areas of radiating pain, and be sure to include all affected areas.

^^^Aches **oooo Numbness** **●●●●Pins/Needles** **xxxx Burning** **////Stabbing**



_____ **Initial**