Welcome to Titus Family Chiropractic - Dr. Todd Titus

Our Goals:

1. Find the cause of your pain and reduce any symptoms as soon as possible.
2. Provide specific home instructions and exercises to help reduce future injury.
3. Give outstanding customer service with compassion and honesty.

Most patients respond to care in 4 to 6 visits. It is very important that you follow all the doctor's recommendations, this will allow for optimal healing. Please communicate with us immediately if you have any questions or concerns. We specialize in treatment involving many conditions but this is not a medical clinic. It is important for you to see your medical practitioner as soon as possible to check you for any medical problems. If you need one, please ask us for a referral. We are a chiropractic (done by hand) clinic focusing on the musculoskeletal system which protects the related neurological system. We will perform a detailed neurological & orthopedic physical exam to determine if we can help you. Further tests may include X-ray, MRI, or CT scan. Treatment may include Active Release Technique, massage, laser therapy and spinal adjustments. If you are not improving or your condition is worsening, a referral to the proper specialist or diagnostic test will be made. It is always a good idea to communicate with all your doctors. Please list any doctors you would like us to send reports to.

Doctor: _____ #: _____ Doctor: _____ #: _____

Confidential Patient Information

Name: _____ Date: _____ Social Sec. Number: _____

Date of Birth: _____ Age: ____ Gender: M or F Marital Status: _____ # of Children: _____

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

Home Phone #: _____ Cell: _____ Email: _____

Occupation: _____ Company Name: _____ Work Phone: _____

How did you hear about us? _____

Payment Options: Cash ----- Check ----- Credit Card ----- Health Insurance ----- Auto Insurance

Have you been in an Auto/Work Accident? ----- Past Year ----- Past 5 Years ----- Over 5 Years ----- Never

Health Insurance Information

Please give all insurance cards to the receptionist so that we can make copies to verify coverage.

Primary Insurance: _____ Secondary Insurance: _____

Financial Agreement

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

*Insurance Cases: Deductible should be met in the beginning unless prior arrangements are made.

**I hereby agree that if my bill must be turned over to a third-party collection agency for non-payment, there will be a collection fee added to my bill of 30%- this is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11". Patient or Guardian

Signature: _____ Date _____

Medical Provider's Contract

This is an agreement between the undersigned patient, hereafter called "patient", and the "provider", for full and complete payment of the provider's medical services and expense by the patient from the proceeds of any insurance settlement, judgement at trial, or recovery from any other means or sources.

This is an obligation coupled with an interest. It is NOT an agreement for payment based upon the outcome of any claim or litigation.

Patient agrees to pay provider regardless of the outcome of any case, claim or litigation in which the provider's reports, notes, care and treatment plan is used.

Following the outcome of the claim, case, or litigation, if collection becomes necessary, patient will then become liable for a 15% collection fee. Accounts past due will be assessed 1.5% interest per month.

A copy of this is to be sent to the patient's attorney with a request the attorney follow these directions in making payment from any recovery to the undersigned provider.

This agreement shall follow the patient and binds all attorneys or firms handling the patients case.

The patient will direct his attorney to withhold payment of the provider's total bill for services/expenses from any settlement or recovery from whatever source and to make payment immediately available to the provider. If the patient is provided payment through an insurance company by settlement, the patient will immediately pay their account balance from their settlement.

This direction is irrevocable and these directions must be followed by the patient's attorney regardless of patient's wishes at a later date.

This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

Read, understood, agreed and signed by these parties on the _____ day of _____ 20___.

_____

Patient Signature

_____

Provider Signature

Informed Consent, HIPPA & Office Policies- Contract

Please read & initial each box, then sign below.

☐ I have been informed that it is not uncommon for patients to have increased discomfort after therapy. If this happens, I will apply ice to the area & rest. If I am concerned about this discomfort or develop any new symptoms I should call the office as soon as possible. If needed, I should present myself to an emergency room or call 911. Treatment is hands on or by machine and with any procedure there are risks and side effects possible. Communication is essential, if I am uncomfortable or concerned about any procedure or have side effects, I am to stop the procedure and tell the doctor immediately.

☐ I hereby request & consent to examination, chiropractic & other procedures to be determined by the doctor- including various modes of physical therapy and massage. Our scope of practice and training does not include the treatment, evaluation or diagnosis of cancer, fractures, tumors, organ pathology, diabetes, vascular, or any medical pathology. I am advised to speak with my medical doctor about all conditions. I understand & am informed that, as in all healthcare, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains/sprains, fractures, disc injuries & strokes. I do not expect the doctor to be able to anticipate & explain all risks, alternatives & complications. I wish to rely on the doctor to exercise judgement which the doctor feels are best at the time, based upon facts then known.

☐ I hereby authorize you and your employees to furnish anyone designated in writing by me, all copies of records & reports, concerning any condition that I may have had in the past, now have, or may have in the future. I give permission to use my address, phone number & clinical records to contact me with appointment reminders, missed appointment notification, phone messages, emails, birthday or holiday cards, information about our clinic, or other health related information. I can revoke this authorization at any time in written form. All my records will be protected & will not be released to others without my consent.

☐ I am responsible for this account. I direct any insurance company, attorney, or other person who holds or later holds proceeds to apply it to my account at this clinic, as payment toward total charges for professional services rendered. I agree to pay in a timely manner, any balances of said applicable charges. I agree that this office be given power of attorney to endorse all drafts for payment of my bill. All co-pays and deductibles are due at the time of service. I understand that I will be responsible for any collection of court fees involved if the account must be sent to collections. I also certify that I am not using a false identity.

I understand that all the above is legally binding and that this contract can only be modified by addendum signed by both parties. If I do not understand or agree with any of the above, I will discuss this with the doctor. I will not sign below if I do not understand or agree to fully honor this agreement. I also intend that this agreement is permanent, irrevocable and binding. I have read, understand and agree to all the above.

Print Patient's Name Patient Signature (or parent/guardian) Date

Claim Information

YOUR INSURANCE INFORMATION:

Name:_____ Date:_____

Date of Injury: _____

Name of Insurance company:_____

Adjustors Name:_____ Phone # :_____

Claim #:_____ Fax #: _____

Mailing address of Insurance Company:

_____

_____

Do you have Med Pay? Yes No

Please Indicate the amount of medical benefits permitted on your policy
$_____

OTHER PARTIES INSURANCE INFORMATION:

Name:_____ Date:_____

Date of Injury: _____

Name of Insurance company:_____

Adjustors Name:_____ Phone # :_____

Claim #:_____ Fax #: _____

Mailing address of Insurance Company:

_____

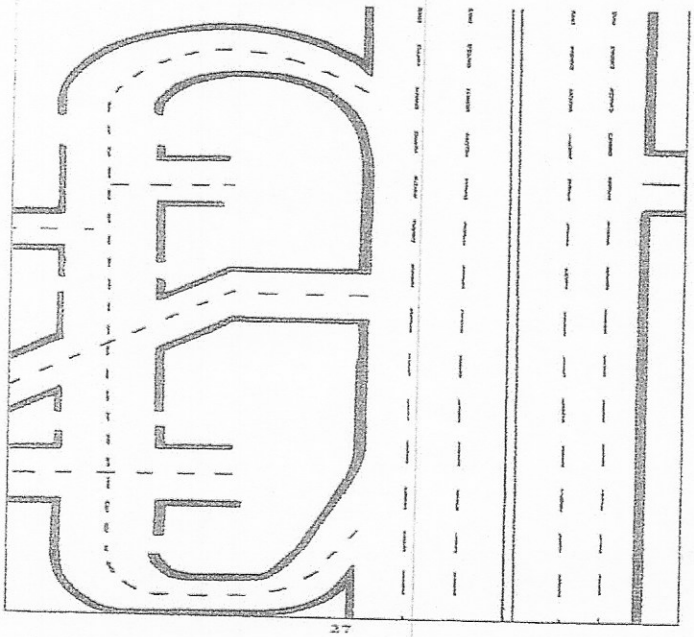
_____

What is the make, model and year of the vehicle you were in?	What is the make, model and year of the vehicle that hit you?
Approximately, how fast was the vehicle you were in going? Was you foot on the break?	Approximately, how fast was the other vehicle going? What was the posted speed?
Approximately, how much damage was done to you vehicle?	Approximately, how much damage was done to the other vehicle?
What is wrong with your car?	Did the police issue a report? Please give us a copy
Did the driver of your car or you get cited or a ticket?	Did the driver of the other car get cited or a ticket?
Did your car roll over?	How many cars were involved in the collision?
Was the car your were in able to be driven away?	Was the other car able to be driven away?
Was anyone else in your car injured?	Do you have any cuts or bruises?
Was the road dry, wet, icy?	Did you hear the car break (or any sound) before it hit you?

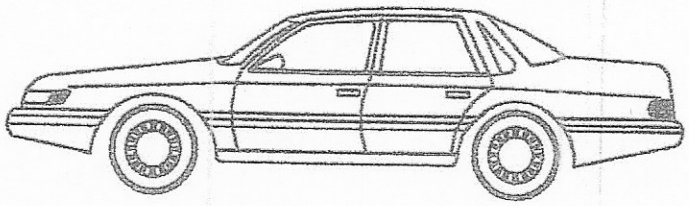
Please draw a diagram of the accident and show the point of impact & damage to your vehicle

*Please be as detailed as possible

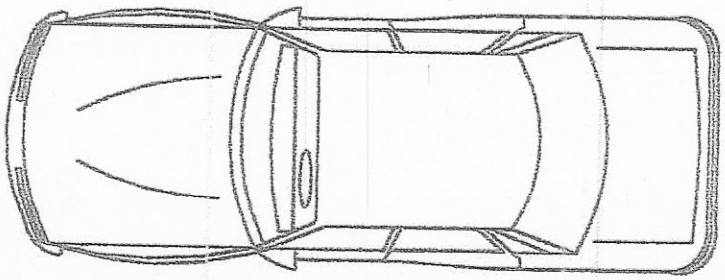
Road diagram



Side view of damage to the car you were in



Top view of damage to the car you were in



Please describe in you own words, what you feel happened in the accident:

Signature: _____ Date : _____

PAST / OTHER MEDICAL HISTORY			
FAMILY MEMBER'S HISTORY	Similar problems?	Yes No	If yes, who?
	Disability	Yes No	If yes, who?
	Arthritis	Yes No	If yes, who?
	Heart Disease	Yes No	If yes, who?
	Diabetes	Yes No	If yes, who?
	Neck Pain	Yes No	If yes, who?
	Back Pain	Yes No	If yes, who?
Have you ever had an MRI, X-ray or CT scan?		Yes No	If yes, results?

HOSPITALIZATIONS	Year	Illness/Operation		Remaining problems

PREVIOUS TRAUMA (Automobile accident, fractures, strains, any other)	Date	Injury/Accident		Remaining problems

ALLERGIES (medications or environmental)					
MEDICATIONS (please all medications you take—even if only occasionally)	Medication	Dose	How Often	When Started	Why?

ACCIDENT QUESTIONAIRE

YOU

*If you do not understand a question circle it.

Date of Accident			
Did the pain start instantly	Yes	NO	If no, when did it start?
Did you lose consciousness	Yes	NO	How long?
Did you go to the hospital	Yes	NO	If yes, name of hospital? Date?
X-ray, MRI or CT scan performed	Yes	NO	Results?
Did you see you PCP	Yes	NO	Name of doctor?
Any other healthcare providers	Yes	NO	Name of providers?
Have you been diagnosed	Yes	NO	With what?
Prescribed medications	Yes	NO	What?
Injections	Yes	NO	Where?
Have you missed work	Yes	NO	How many days?
What are you doing for the pain?			Neck collar, Ibuprofen, back brace, cane, other:

VEHICLE

Were you the driver	Yes	NO	If no, where were you sitting?
Were you wearing a seatbelt	Yes	NO	Did it bruise you?
Were you surprised by the impact	Yes	NO	
Was your head turned before impact	Yes	NO	Which way was your head or body turned?
Any part of your body hit inside of car	Yes	NO	Which body part?
Did the airbags deploy	Yes	NO	Any problems?
Was there a second impact	Yes	NO	What was hit?
Did the seat break	Yes	NO	
Was you seat tilted / reclined back	Yes	NO	How far?
Did your head hit the headrest	Yes	NO	Where did the headrest hit your head?
Both hands on the steering wheel	Yes	NO	If no, which hand on wheel?

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

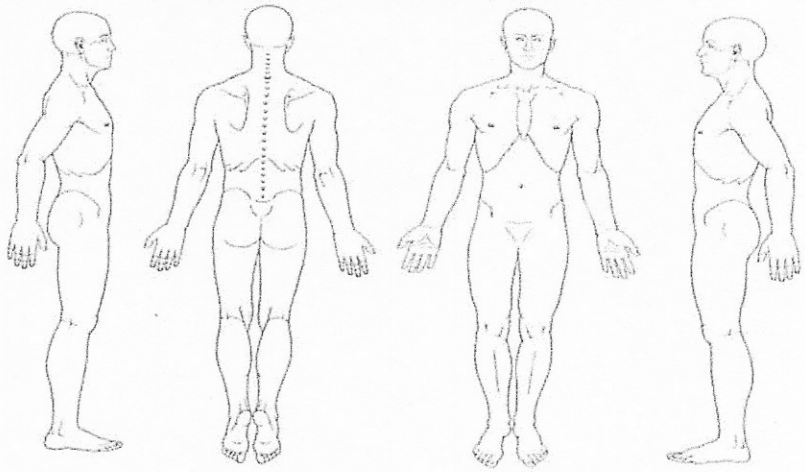
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered 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. During the <u>past 4 weeks</u> how much of the time has your condition 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

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

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Name: _____ Date: _____

QuickDASH Questionnaire

This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	No Difficulty	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*Unable*
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (eg., wash walls, floors)	1	2	3	4	5
3. Carry a shopping bag or briefcase	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder, or hand (eg., golf, hammering, tennis, etc.)	1	2	3	4	5
	Not At All	*Slightly*	*Moderately*	*Quite a Bit*	*Extremely*
7. During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups?	1	2	3	4	5
	Not Limited At All	*Slightly Limited*	*Moderately Limited*	*Very Limited*	*Unable*
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week (circle number)	*None*	*Mild*	*Moderate*	*Severe*	*Extreme*
9. Arm, shoulder, or hand pain	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder, or hand	1	2	3	4	5
	No Difficulty	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*So Much Difficulty That I Can't Sleep*
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand? (circle number)	1	2	3	4	5

Score: _____

Name: _____ Date: _____

WORK MODULE (OPTIONAL)					
The following questions ask about the impact of your arm, shoulder, or hand problem on your ability to work (including homemaking if that is your main work role).					
Please indicate what your job/work is:					
Please circle the number that best describes your physical ability in the past week.					
Do you have any difficulty:	*No Difficulty*	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*Unable*
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder, or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)					
The following questions relate to the impact of your arm, shoulder, or hand problem on playing your musical instrument, or sport, or both. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.					
Please indicate the sport or instrument which is most important to you:					
Please circle the number that best describes your physical ability in the past week.					
Do you have any difficulty:	*No Difficulty*	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*Unable*
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder, or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practicing or playing your instrument or sport?	1	2	3	4	5

DASH Disability/symptom score = ([(sum of n responses) / n] - 1) * 25

Score: _____