Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Chiropractic Partners
3319 Durham-Chapel Hill Blvd.
Durham, NC 27707
Phone: (919) 383-9890

## NEW PATIENT INTAKE

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____/_____/_____ Age _____ SSN# _____ - _____ - _____

Gender: ☐ Male ☐ Female Email: _____

How did you hear about our office? _____

### EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

### CURRENT MEDICATIONS

| Name of Medication | Start Date | Name of Medication | Start Date |
|---|---|---|---|
| ◊ _____ | _____ | ◊ _____ | _____ |
| ◊ _____ | _____ | ◊ _____ | _____ |
| ◊ _____ | _____ | ◊ _____ | _____ |
| ◊ _____ | _____ | ◊ _____ | _____ |

### ALLERGIES

| | |
|---|---|
| ◊ _____ | ◊ _____ |
| ◊ _____ | ◊ _____ |
| ◊ _____ | ◊ _____ |

### COORDINATED CARE

For the purposes of coordinating care, we recommend that we send records to your referring/primary physician.

☐ I do not want my records sent to my physician ☐ I give permission to release my records to the listed physician(s)

Physician: _____ Facility: _____

Physician: _____ Facility: _____

Patient Signature: _____

# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/20(

**Patient Name** _____ **Date** _____

**1. Describe your symptoms** _____

_____

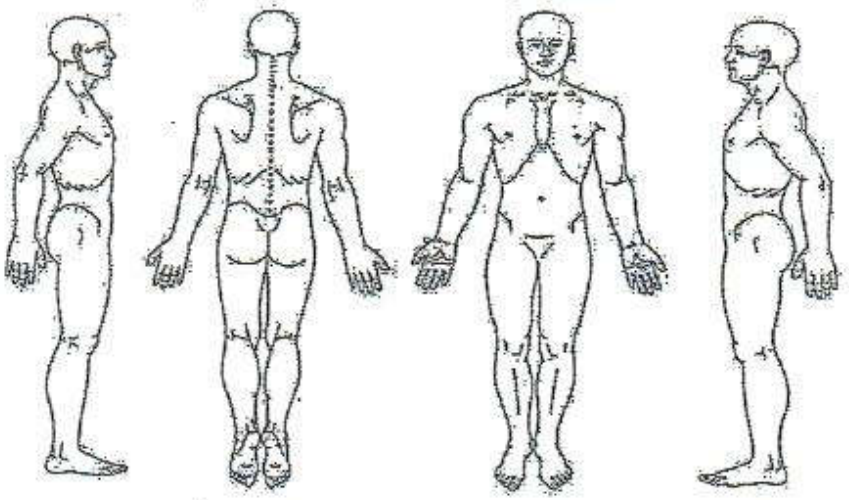
a. When did your symptoms start? _____

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 past 4 weeks:**

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 past 4 weeks 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 ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

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 ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

**10. What is your occupation?**

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

_____

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

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

**Patient Signature** _____ **Date** _____

Patient Name: _____ Date: _____

**MEDICAL CONDITIONS**

| | | | |
|---|---|---|---|
| ☐ Hypertension | ☐ Bowel Problems | ☐ Dizziness/Vertigo | ☐ Weight Loss/Gain |
| ☐ Heart Disease | ☐ Constipation | ☐ Difficulty Swallowing | ☐ Difficulty Sleeping |
| ☐ Stroke | ☐ Nausea/Vomiting | ☐ Skin Disease | ☐ Head Injury |
| ☐ Cancer | ☐ Poor Appetite | ☐ Immune Disorder | ☐ Osteoporosis |
| ☐ Easy Bruising/Bleeding | ☐ Bloody Stools | ☐ Thyroid Disease | ☐ Broken bones |
| ☐ Asthma | ☐ Gout | ☐ Diabetes | ☐ Shortness of Breath |
| ☐ Shortness of Breath | ☐ Arthritis | ☐ Fevers/Chills/Sweats | ☐ Numbness |
| ☐ Blood Clots | ☐ Swelling of Legs | ☐ Aneurysm | ☐ Balance Issues |

Other: _____

**SURGERIES** (Please list type of surgery and approximate date)

◊ _____ ◊ _____
◊ _____ ◊ _____
◊ _____ ◊ _____

**FAMILY HISTORY**

| | *Parent* | *Sibling* | | *Parent* | *Sibling* | | *Parent* | *Sibling* |
|---|---|---|---|---|---|---|---|---|
| • Arthritis | ☐ | ☐ | • Cancer | ☐ | ☐ | • Psychiatric | ☐ | ☐ |
| • Cholesterol | ☐ | ☐ | • Diabetes | ☐ | ☐ | • Stroke | ☐ | ☐ |
| • Heart Problems | ☐ | ☐ | • Hypertension | ☐ | ☐ | • Thyroid | ☐ | ☐ |

**SUBSTANCE USE**

| | *Present* | *Past* | | *Present* | *Past* | | *Present* | *Past* |
|---|---|---|---|---|---|---|---|---|
| • Alcohol | ☐ | ☐ | • Tobacco | ☐ | ☐ | • Heroin | ☐ | ☐ |
| • Opioids | ☐ | ☐ | • Marijuana | ☐ | ☐ | • Cocaine | ☐ | ☐ |
| • Barbituates | ☐ | ☐ | • Amphetamines | ☐ | ☐ | • Other _____ | | |

On occasion we may wish to send prescribed exercises via email, for which we utilize an online company called WebExercises®. Additionally, the lab results for our BrainSpan™ testing can be emailed by request. Be aware that communication via email is not encrypted and therefore comes with some degree of risk of being read by someone else. We will never email either of the above mentioned items without your express permission. You have the option of requesting paper copies of these documents.

☐ I would like to utilize any WebExercises® sent to me via email and understand the innate associated risk
☐ If I have lab work performed and request the results via email, I understand the innate associated risk

# INSURANCE POLICY FOR OFFICE OF DR. MICHAEL KRASNOV, D.C.

- **COMMERCIAL INSURANCE**

We will file your insurance; however, it is your responsibility to understand your insurance plan. Although we verify benefits as a service to you, we cannot guarantee your insurance will pay according to the benefits quoted to us and therefore there are **no guarantees of payment** from your insurance company. Unless otherwise prohibited, **any balance not paid by your insurance company within 90 days of our billing date is your responsibility.**

Payment of deductible, coinsurance, copays, and any non-covered services, based on the information provided to us by your insurer, is due and payable **at the time of service**

- **PERSONAL INJURY**

If your condition is due to a motor vehicle accident, we retain the right to file **ANY** available insurance, such as Medpay or health insurance. You will be responsible for any non-covered balance. If you retain an attorney we agree to work with or there is a liable insurance company, we will wait to receive payment from them for up to one year from completion of treatment. **Any balance is immediately due and payable** under the following conditions: 1) you terminate care without your doctor's approval, 2) you fail to notify us that you are no longer represented by the attorney we have on record, 3) you receive payment in whole or in part for our services from a third party Including MedPay and do not promptly use it to settle any balance due, of 4) you fail to cooperate with our efforts to receive third party reimbursement. Until we can verify your insurance coverage and/or legal representation, you may be asked to pay for your services in full.

- **WORKER'S COMPENSATION INJURY**

Almost all employers carry industrial insurance to cover treatment of your Worker's Comp injury. There is no out of pocket expense to the patient on **APPROVED** job-related injury claims; however we must receive from your employer and/or employer's insurance carrier approval **prior to** your examination and treatment for this direct billing. Patient without prior approval are required to pay for their services at the time of service. Any payments made by the patient prior to approval are reimbursed after this office receives payment from the insurance carrier.

- **MEDICARE**

Medicare **only pays for spinal manipulation** and only if they consider it medically necessary. They ***do not*** cover any other services.

SIGNATURE (*Medicare patients only*): _____ Date: _____

- **CASH**

If you do not wish us to file any type of insurance, and you pay us in full at the time of service, will be set up as a "cash" patient. This entitles you to a discount off our regular rates. If you have insurance and ask us not to file your insurance, you can change your mind in the future, but past visits will not be filed.

**THERE IS A $25 RETURNED CHECK FEE FOR ALL RETURNED CHECKS**

I understand the above information and agree to pay any amount not covered by my insurance carrier or liable party, unless otherwise prohibited. I agree to pay any costs associated with collecting payments over 30 days past due. This includes any late fees, interest, attorney's fees, and court costs.

***All durable medical equipment, electro-stimulation pads, supplements, miscellaneous supplies, and video rentals which may not be covered by my insurance plan must be paid for upon receipt. Returns cannot be accepted on any supplies and products that are not in new condition. Returns must be made within 14 days of purchase. Refunds for items made within 14 days of purchase. Refunds for items paid by check will be issued after the check clears.***

**We request the courtesy of 24-hour advance notice if you are unable to keep your appointment. Failure to do so on a repeated basis may result in the loss of scheduling privileges.**

PRINTED NAME: _____

PATIENT SIGNATURE: _____ Date: _____

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Michael Krasnov, D.C., C.C.S.P.
3319 Durham Chapel Hill Blvd.
Durham, NC 27707
(P)919-383-9890

# Doctor's Lien

Ref: _____

Claim #: _____

Date: _____

From: Dr. Michael Krasnov
3319 Durham Chapel Hill Blvd
Durham, NC 27707

I do, hereby give a lien to above doctor on any settlement, claim, judgment, or verdict as a result of my accident/illness which occurred on _____. I authorize and direct you to pay directly to said doctor any/all sums that may be due for any/all services rendered to me. I authorize you to withhold such sums from any settlement, claim, judgment, or verdict, and to protect said doctor adequately. I understand that I am directly and fully responsible to said doctor for any/all services billed by him for services rendered to me, and that this agreement is made to further protect the doctor's reimbursement of services rendered, and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, or verdict that I may eventually recover. This lien shall be irrevocable, until such time that all of the doctor's bills have been paid in full.

Patient's Name_____ Date_____

Patient's Signature_____

Witness_____

Confirmation of Receipt and Compliance

The undersigned, being the attorney of record or an authorized representative of insurance carrier, for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor this lien to protect the above named doctor, as detailed: Pursuant to NCGS.44-49 and 44-50.

Name of Authorized Representative_____

Authorized Signature_____ Date:_____

Please sign, date, and return original copy to the doctor's office at address shown above. Please make a copy for your records.

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

## Assignment of Benefits

**IN CONSIDERATION** of the willingness of Dr. Michael Krasnov to treat me on credit without demand for payment at the time of services are rendered, I hereby agree and stipulate as follows:

**I irrevocably assign to Dr. Michael Krasnov** any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Dr. Michael Krasnov, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Dr. Michael Krasnov for his services rendered.

**I appoint Dr. Michael Krasnov** as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and which was issued in payment of services received by Dr. Michael Krasnov, and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Dr. Michael Krasnov.

**I authorize Dr. Michael Krasnov** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

**I acknowledge that I remain personally liable** for the total amount due to Dr. Michael Krasnov for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Dr. Michael Krasnov is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Dr. Michael Krasnov for his costs of recovery, including reasonable attorney's fees.

_____ _____

Patient Date

_____

Witness

### Notice of Lien

**Pursuant to NCGS 44-49 and 44-50,** Dr. Michael Krasnov hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained; whether in litigation or otherwise.

Dr. Michael Krasnov hereby requests that if his claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with NCGS 44-50.1. Dr. Michael Krasnov agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

# Questionnaire for Personal Injury

Patient's Name _____ Date of the Accident: _____

Do you have an attorney (please circle: YES / NO )? If yes,

What is your attorney's name? _____ Phone #: _____

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

Were there witnesses to the accident (please circle: YES / NO )? If yes,

Name(s) of witnesses: _____ Phone #: _____

_____ Phone #: _____

## Auto Insurance Information:

1. The vehicle in which you were riding:

   Owner: _____

   Ins. Co. Name: _____ Policy #: _____

   Ins. Co. Agent: _____ Agent Phone #: _____

   Ins. Co. Adjustor: _____ Adjustor Phone #: _____ Claim #: _____

2. Your vehicle (if different than above):

   Owner: _____

   Ins. Co. Name: _____ Policy #: _____

   Ins. Co. Agent: _____ Agent Phone #: _____

   Ins. Co. Adjustor: _____ Adjustor Phone #: _____ Claim #: _____

3. Vehicle that hit the car in which you were riding:

   Owner: _____

   Ins. Co. Name: _____ Policy #: _____

   Ins. Co. Agent: _____ Agent Phone #: _____

   Ins. Co. Adjustor: _____ Adjustor Phone #: _____ Claim #: _____

4. Was a violation citation issued (please circle: YES / NO )?

   _____ To driver of other vehicle _____ To driver of your vehicle

5. Were you (please circle: DRIVING / A PASSENGER )?

# AUTOMOBILE/ACCIDENT QUESTIONNAIRE

**Patient Name:** _____ **Date:** _____

## VEHICLE YOU WERE IN

**Vehicle type?**
☐ Car ☐ Pickup ☐ Van ☐ Truck ☐ Station Wagon
☐ Bus ☐ Other _____

**Vehicle size?**
☐ Subcompact ☐ Full-Size ☐ Compact ☐ Mini
☐ Mid-Size ☐ Light ☐ Other _____

**What was your location in the vehicle?**
☐ Driver ☐ Front Passenger ☐ Rear Passenger
Passenger Location: ☐ Left ☐ Middle ☐ Right
☐ Other _____

**What was the vehicle you were in doing?**
Mark only one box for the above question
**Vehicle stopped for** ☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Pedestrian ☐ Parked
☐ Other _____

**Vehicle slowing down for** ☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Pedestrian ☐ Turning
☐ Parking ☐ Other _____

**Vehicle moving** ☐ Slowly ☐ Moderately ☐ Fast
☐ _____ MPH ☐ Accelerating
☐ Other _____

**What damage did the vehicle you were in sustain?**
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other _____

**What damage did this vehicle sustain?**
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other _____

**Second vehicle to strike the vehicle you were in**
**Vehicle type?** ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other _____

**Vehicle size?** ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other _____

**How did this vehicle strike the vehicle you were in?**
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other _____

**What damage did this vehicle sustain?**
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other _____

**Describe other vehicles to strike the vehicle you were in**
☐ Vehicle Type: _____
☐ How it struck: _____
☐ Vehicle Size: _____
☐ Damage: _____

**Were traffic citations issued as a result of the accident?**
☐ No citations issued ☐ Driver of other vehicle
☐ Driver of vehicle you were in ☐ You
☐ Unsure

## IF OTHER VEHICLES INVOLVED IN ACCIDENT

**First vehicle to strike vehicle you were in**
**Vehicle type?** ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other _____

**Vehicle size?** ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other _____

**How did this vehicle strike the vehicle you were in?**
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other _____

## AT MOMENT OF IMPACT

**Were you prepared for the accident?**
☐ Accident was a complete surprise
☐ Aware of impending collision
☐ Braced for impact

**Was your foot on the brake pedal at impact?**
☐ Yes ☐ No

**Were you wearing a restraint belt?**
☐ Yes ☐ No

**What type of restraint belt were you wearing?**
☐ Shoulder-Lap Belt ☐ Shoulder Belt ☐ Lap Belt

**Was your vehicle equipped with air bags?**
☐ Yes ☐ No ☐ Unsure