Oasis Chiropractic and Wellness Center
41 Summers Way, Suite 103
Roanoke, VA 24012
540-966-1423

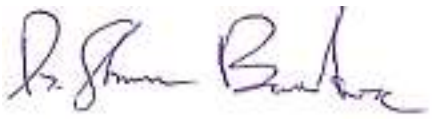
WELCOME to our Chiropractic Clinic.

I am genuinely grateful that you have come to us and that I have this opportunity to serve you as my patient. From time to time I am going to take the liberty of writing to you about significant phases of your treatment and care. Needless to say, I will always welcome any inquiries you may have. Indeed, I will want to address your questions personally.

Our goal here at Oasis Chiropractic is to give hope, health and healing to the hurting!

Again, thank you. Let me add that if a friend or relative referred you as my patient, please pass along my sincere appreciation.

Sincerely



Dr. Thomas M. Baader, D.C
Clinical Director

OASIS Wellness Center

Patient Intake Form

Account # _____

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____ **Birthdate**:_____/_____/_____

Gender: □ Male □ Female □ Unspecified **Age**: _____

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

Primary Phone:_____ **Cell Phone**:_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Email □ Text Message

Patient Employer/School:_____ **Occupation**:_____

Choose One: □ Married □ Separated □ Widowed □ Divorced □ Single □ Partnered for _____ years.

Spouse's Name: _____ **Spouse's Birthdate:** _____/_____/_____

Who may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT

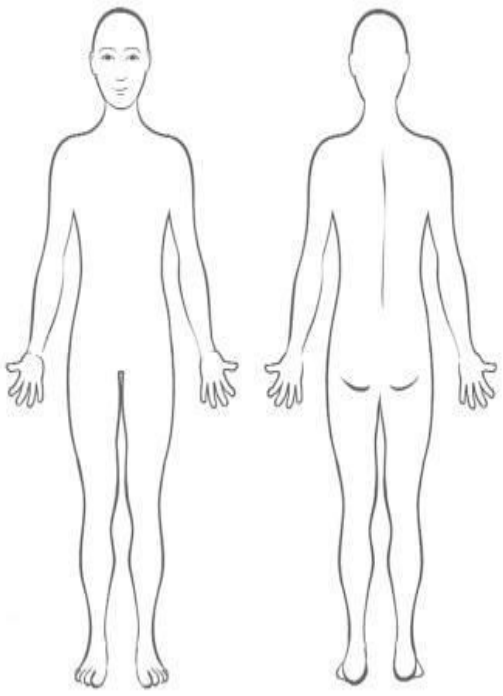
Name: _____

Relationship: _____

Phone Number: _____

REASON FOR VISIT

What is the reason for your visit today? _____



When did this complaint begin? _____/_____/_____

Is the condition getting worse?: □ Yes □ No □ Unknown

*Mark an X on the picture where the pain is located.

Rate the severity of the pain from 0-10: _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □Shooting □ Burning □ Tingling □ Cramping □ Stiffness □ Swelling □ Other: _____

How often do you have this pain?

_____

Is this pain: □ Constant □ Come and go

Does the pain interfere with: □ School □ Sleep □ Daily Routine □ Other Activities: _____

Activities that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

HEALTH HISTORY

Have you had any: □ Falls □ Head Injuries □ Broken Bones □ Dislocations □ Surgeries:

_____

Are you currently taking any medications? □ Yes □ No

Is there a chance you could be pregnant? □ Yes □ No Due Date: _____

Please check the box if you have had **ANY** of the following:			
□ AIDS/HIV	□ Fractures	□ Mumps	□ Tumors, Growth
□ Alcoholism	□ Glaucoma	□ Osteoporosis	□ Typhoid Fever
□ Allergy/Shots	□ Goiter	□ Pacemaker	□ Ulcers
□ Anemia	□ Gonorrhea	□ Parkinson's Disease	□ Vaginal Infections
□ Anorexia	□ Gout	□ Pinched Nerve	□ Whooping Cough
□ Appendicitis	□ Heart Disease	□ Pneumonia	□ Other: _____
□ Arthritis	□ Hepatitis	□ Polio	
□ Asthma	□ Hernia	□ Prostate Problem	
□ Bleeding Disorders	□ Herniated Disk	□ Prosthesis	
□ Breast Lump	□ Herpes	□ Psychiatric Care	
□ Bronchitis	□ High Blood Pressure	□ Rheumatoid Arthritis	
□ Bulimia	□ High Cholesterol	□ Rheumatic Fever	
□ Cancer	□ Kidney Disease	□ Scarlet Fever	
□ Cataracts	□ Liver Disease	□ Sexually Transmitted Disease	
□ Chemical Dependency	□ Measles	□ Stroke	
□ Chicken Pox	□ Migraine Headache	□ Suicide Attempt	
□ Diabetes	□ Miscarriage	□ Thyroid Problems	
□ Emphysema	□ Mononucleosis	□ Tonsillitis	
□ Epilepsy	□ Multiple Sclerosis	□ Tuberculosis	

Exercise: □ None
□ Moderate
□ Daily
□ Heavy

Work Activity: □ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits: □ Smoking Packs/Day: _____
□ Alcohol Drinks/Week: _____
□ Coffee/Caffeine Drinks Cups/Day: _____
□ High Stress Level Reason: _____

ASSIGNMENT AND RELEASE

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with _____ and assign directly to Dr. Thomas Baader all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian or Representative **Relationship to Patient**

Account #: _____

THIS NOTICE DISCLOSES HOW MEDICAL INFORMATUON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY*.

Uses and Disclosures:

A. We may disclose your protected health information without your written consent, written authorization, or oral agreement for the following purposes:
Treatment *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
Payment *Example:* We may disclose your health information to a third party, such as an insurance carrier, and HMO, PPO, or your employer, in order to obtain payment for services provided to you.
Health Care Operations *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

B. We may use or disclose your protected health information without your written consent, written authorization, or oral agreement in the following circumstances if we provide services to you:
   - While you are an inmate
   - In an emergency treatment situation
   - If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
   - If there are substantial barriers to communication and we determine, in the exercise of our professional judgement that you intend for us to treat you.
   - If we need to notify, or assist in the notification of a family member personal representative or another person responsible for your care of your location, general condition or death.
   - If we are required by law to disclose your health information to a public health or another government authority that is authorized to receive reports of child abuse or neglect.
   - If we are required to disclose your health information to the Food and Drug Administration
   - If we are required to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.
   - If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
   - If we are required to disclose your health information in response to a court order subpoena.
   - If we are required to disclose your health information to a law enforcement official.
   - If we are required to disclose your health information to a coroner, medical examiner, or funeral director.
   - For research purposes.
   - If we, in good faith, believe that the use of your health information to comply with law established to provide benefits for work-related injuries, or illness.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OF DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Account # _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

SSN: XXX-XX-_____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZED OASIS SPINAL CARE CENTER, INC. TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Specific Authorization:

I give permission to Oasis Spinal Care Center, Inc. to use my address, phone number, email address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday cards, information about treatment alternatives or other health related information.

If Oasis Spinal Care Center, Inc. contacts me by phone, I give permission to leave a phone message on my answering machine or voicemail.

Open Room Authorization:

I give Oasis Spinal Care Center, Inc. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Oasis Spinal Care Center, Inc. permission to use and disclose your protected health information in accordance with the directive listed above.

Right to Revoke Authorization:

You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to Oasis Spinal Care Center, Inc. The written notice must contain the following information: Name, last 4 digits of SSN, date of birth, statement of your intent to revoke this authorization, date of your request, and signature. **This revocation is not official until received by Oasis.**

This authorization is requested by Oasis Spinal Care Center, Inc. for its own use/disclosure. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Oasis Spinal Care Center, Inc. will not refuse treatment. You have the right to inspect or copy the form to be used/disclosed.

Patient Name: _____

Patient Signature: _____ Date: _____

Oasis Chiropractic and Wellness Center

Drs. Tom and Karen Baader, D.C.
41 Summers Way, Suite 103
Roanoke, VA 24012
540-966-1423

Account # _____

Chiropractic care is a safe and effective form of natural health care. However, as is the case with every form of treatment, certain risk exists. Chiropractic treatment involves the physical movement of bones and joints. Certain pathological defects, illnesses, or deformities can be difficult to detect.

As your Chiropractor, I will take reasonable precautions to avoid any negative reactions to treatment. However, it is extremely important that you assist me by providing accurate information about your medical history and promptly inform me of any changes in your health or physical condition. We do not offer to diagnose or treat any condition other than vertebral subluxation. If, during your chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you to seek the services of a healthcare provider who specializes in that area, if you desire advice, diagnosis, or treatment for those findings.

Severe reactions to chiropractic care are rare, but it is my duty to inform you of the risks involved. Please discuss any questions with me prior to signing this consent form.

_____ _____

Signature of Patient Date

Request for Treatment

On accordance with Virginia State Law, having received an examination and/or x-rays at a reduced fee, oasis Chiropractic is obligated to delay treatment for 72 hours unless this portion of the Chiropractic Consent Form is signed.

_____ _____

Signature of Patient Date

Oasis Chiropractic and Wellness Center

Drs. Tom and Karen Baader, D.C.

At, Oasis Chiropractic, we excel at giving advice, recommendations and care that is tailored for each individual's specific needs. We continue to give our best to provide exceptional care to all of those that we are blessed to serve. Our goal is to respect your time and allow you to live life without any interruptions; striving to make your care affordable and effortless. To accomplish this we have implemented a few office policies to make your experience as wonderful as possible. We ask that you:

1. Schedule your appointments in advance to assure you have the same time, every week. (no need to stop at the front desk)
2. Place a Required Credit/Debit/Health Savings card on file, in our safe and encrypted software program. Each office visit and supplement will be charged to your account, eliminating the hassle of waiting in line. If you choose to use a different form of payment, at any time, please let us know as you enter the building.
3. In our effort to provide the best care possible and be respectful of our patients' time, we expect a commitment from each individual to show up promptly for their given appointment time. Please call 24 hours in advance if you need to reschedule your appointment. A $25 missed appointment fee will be charged to your account if we do not hear from you. We appreciate the notice so that we can allow others that are in pain to get in.
4. Our fees, beginning February 2022, are the following:

Adjustment	$49 per adjustment
X-Ray	$49 per x-ray
Consult/Metabolic Appt.	$49 per 15 min
Medicare	$49 per adjustment
(Medicare does NOT cover chiropractic x-rays.)	
Missed Appointment Fee	$25

Dr. Tom, at his discretion, provides the following services, complimentary:

Bone Matrix Magnifier
Impedance Body Composition Analyzer
Therapy exercises
Percussion at tableside
Massage Chairs
Postural Correction Devices
Red Light Therapy

Thank you again for allowing us to be part of your health and wellness.

****

NEW PATIENTS: *Please sign and date the statement below:*

I understand and accept the policy requirements and expectations as outlined above.

_____ _____

NAME *DATE*

_____

PRINT NAME

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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