Dr. Erika K. Bruns Montemerlo, D.C.
15 Wild Horse Run
Kennebunkport, ME 04046
Ph (207) 356-8688

Welcome! We are pleased that you chose PURE Center for Integrated Health to evaluate your condition. Would you please fill out the information below, so that we may properly file your insurance claims for you? If you would like assistance, please inform the front desk personnel and they will be happy to help you.

PERSONAL INFORMATION

Last Name: _____ First:_____ Middle:_____ DOB:_____ Age:____
SSN:_____ Home Phone:_____ Cell Phone:_____ Work Phone:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Email Address:_____ Employer:_____ Occupation:_____
Marital Status ☐Single ☐Married- Spouse's SS#_____ DOB_____ ☐Widowed ☐Divorced ☐Other
Emergency Contact: _____ Relationship:_____ Phone:_____

Who is responsible for the payment of your bill? ☐ Self-Pay/Cash ☐ Major Medical Health Ins. ☐Medicare ☐ MaineCare ☐ Employer ☐ Worker's Comp. Ins. ☐ Auto/Personal Liability Ins. ☐ Other: _____

HEALTH CARE INFORMATION

Primary Care Provider:_____ Office Location:_____ Phone:_____
Was this visit pre-approved? Yes No
Other Provider:_____ Office Location:_____ Phone:_____

Medical Records Release: By signing below, I authorize Dr. Bruns and her staff to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed above for the purpose of insuring I receive proper treatment.

Patient or Guardian's signature: _____Patient's Date of Birth: _____

Primary Health Insurance Name:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
ID Number:_____ Group ID Number:_____

Secondary Health Insurance (if applicable)
Name:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
ID Number:_____ Group ID Number:_____

IF THIS IS AN AUTOMOBILE ACCIDENT OR WORK RELATED INJURY, PLEASE COMPLETE THIS BOX

Name of Insurance:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Adjusters' Name:_____ Claim Number:_____
Has this claim been denied by Worker's Compensation? Yes No

Name of Attorney:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____

I,_____, (Patient's Signature) state that the information above is valid. Date:_____

This Box is for Office Use Only- Vital Signs Height: ____' ____" Weight: _____ Lbs. Dominant Hand: L R

Left Seated Blood Pressure: _____/_____ Left Pulse: _____/min. Respiration: _____/min

Right Seated Blood Pressure: _____/_____ Left Pulse: _____/min. Temperature (oral): ____° Office Staff Initials:____

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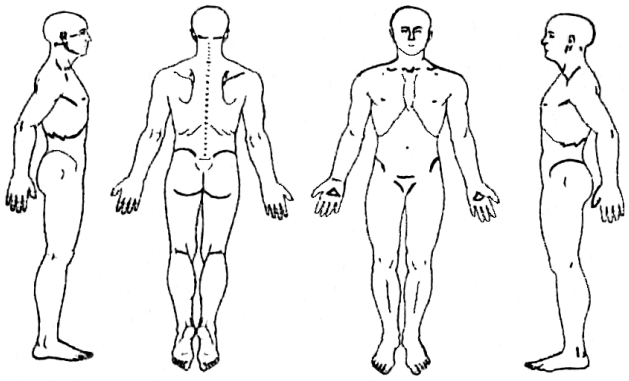
HISTORY OF PAIN, INJURY AND/OR ILLNESS

Print Patient's Name:_____ **DOB:**_____ **Date:**_____

1. On the figure below please mark the location of ALL symptoms or complaints using a circle or an X.

Using an X or a circle, mark the area on the drawing where each symptom or complaint is located	Descriptions/ Letter Key	Additional Notes
	A = Ache B = Burning D = Dull Pain DD = Deadness N = Numbness P = Pain S = Sharp SH = Shooting ST = Stabbing T = Tight TG = Tingling TH = Throbbing O = Other PWM= Pain with movement	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

TIMING, DURATION & SEVERITY

2. Please describe each individual symptom below (most severe first) using the descriptions provided in both the descriptions letter key above and the frequency/intensity grades chart below.

Please list **ALL** symptoms you are experiencing.		Frequency % of the day	Intensity/Severity 1=Mild 10=Worst
Symptom #1:		____% of day	
Symptom #2:		____% of day	
Symptom #3:		____% of day	
Symptom #4:		____% of day	

3. For each of the conditions/symptoms listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition/symptom listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Hepatitis
☐	☐	Mid Back Pain	☐	☐	Angina	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Low Back Pain	☐	☐	Stroke	☐	☐	Epilepsy
☐	☐	Shoulder Pain	☐	☐	Allergies	☐	☐	Diarrhea
☐	☐	Elbow/Upper Arm Pain	☐	☐	Frequent Urination	☐	☐	Constipation
☐	☐	Wrist Pain	☐	☐	HIV/AIDS	☐	☐	Kidney Stones
☐	☐	Hand Pain	☐	☐	Visual Disturbances	☐	☐	Kidney Disorders
☐	☐	Hip Pain	☐	☐	Depression	☐	☐	Bladder Infection
☐	☐	Knee Pain	☐	☐	Systemic Lupus	☐	☐	Painful Urination
☐	☐	Upper Leg Pain	☐	☐	Loss of Appetite	☐	☐	Abdominal Pain
☐	☐	Ankle/Foot Pain	☐	☐	Chronic Sinusitis	☐	☐	General Fatigue
☐	☐	Jaw Pain	☐	☐	Prostate Problems	☐	☐	Cancer/Tumor
☐	☐	Joint Pain/Stiffness	☐	☐	Muscular Incoordination			
☐	☐	Arthritis	☐	☐	Smoking/Tobacco Use	**For Females Only**		
☐	☐	Rheumatoid Arthritis	☐	☐	Loss of Bladder Control	**Past**	**Present**	
☐	☐	Dizziness	☐	☐	Dermatitis/Eczema/Rash	☐	☐	Hormonal Replacement
☐	☐	Ulcer	☐	☐	Drug/Alcohol Dependence	☐	☐	Birth Control Pills
☐	☐	High Blood Pressure	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnant, Due date_____
☐	☐	Anxiety						

Other Past/Present:_____

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ASSOCIATED SIGNS & SYMPTOMS

Print Patient's Name:_____ DOB:_____ Date:_____

4. Please answer the following questions so that we may better understand your symptoms.

How are your symptoms changing with time? ☐Getting Worse ☐ Staying the Same ☐ Getting Better

How are your symptoms affecting your movement? ☐ Inflexibility ☐ Stiffness ☐ Spasm ☐ Cramps

How much has your problem(s) interfered with your work? ☐ Not at all ☐ Moderately ☐ Extremely

How much has your problem(s) interfered with your social activities? ☐ Not at all ☐ Moderately ☐ Extremely

When did your symptoms begin? (Most Recent Episode) _____ ☐ Days, ☐ Weeks, ☐ Months

How do you think your problem began? ☐Unknown ☐Lifting ☐Overexertion ☐Repetitive Use
☐Slip/Fall ☐Other – describe_____

If this pain radiates or travels, please identify where to:_____

Who else have you seen for your problem(s)? ☐ No one ☐ Chiropractor- Dr. _____ ☐ ER physician
☐ Primary Care Physician- Dr._____ ☐ Orthopedist –Dr._____ ☐ Neurologist – Dr. _____
☐ Massage Therapist_____ ☐ Physical Therapist_____ ☐ Other: _____

If you were treated, what was the result of treatment? ☐ Better ☐ Same ☐ Worse

What makes your symptoms WORSE?_____ What relieves or makes your symptoms feel BETTER? _____

What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Do you consider your problem(s) to be severe?

A. Primary Symptom: ☐ Yes ☐ No ☐ Yes, at times B. Complaint #2: ☐ Yes ☐ No ☐ Yes, at times
C. Complaint # 3: ☐ Yes ☐ No ☐ Yes, at times D. Complaint # 4: ☐ Yes ☐ No ☐ Yes, at times

How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

List any prescription medications you are currently taking: ☐ N/A_____
List any allergic reactions to medications: ☐ N/A ☐ Allergic to: _____

List any over-the-counter medications and vitamin/supplements you are currently taking: ☐ N/A
_____

Have you had any recent injuries, illnesses or falls? ☐ N/A ☐ Yes, _____

List any surgical procedures you have had: ☐ N/A_____
List any recent medical tests and the results: ☐ N/A ☐ X-Ray ☐ CAT Scan ☐ MRI ☐ Bone Scan ☐ EMG ☐ Blood Work

☐ Osteoporosis ☐ Urine test ☐ Colonoscopy ☐ Other: _____Test Result:_____

What activities do you like to do outside of work? _____
Have you ever been hospitalized? ☐ No ☐ If yes, why _____

Have you had any significant past trauma? ☐ No ☐ Yes, (explain) _____

Are you pregnant? ☐No ☐Yes, ____Weeks or Do you think that you may be pregnant? ☐No ☐Yes,_____

Do you have a pacemaker? ☐No ☐Yes,_____

What activities do you do at work?

☐ Sitting:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Standing:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Manual Labor/Hvy Lifting	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Other: _____	☐ Most of the day	☐ Half of the day	☐ A little of the day

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GENERALIZED HEALTH HISTORY

Print Patient's Name:_____ DOB:_____ Date:_____

What concerns you the most about your problem; what does it prevent you from doing? _____

Please list any personal goals you would like to achieve as a result from your treatment with Dr. Bruns:_____

_____

Is there anything else Dr. Bruns Montemerlo should know about your visit today? ☐No ☐Yes,_____

_____

FAMILY HISTORY

7. Please indicate any immediate family members with any major disease or condition including the following: i.e. Rheumatoid Arthritis, Diabetes, Lupus, Heart Problems, Cancer, ALS, Osteoporosis, Other - Describe List by family member:

_____

AUTHORIZATION TO PAY PHYSICIAN

In consideration of the undertaking by Dr. Erika K. Bruns Montemerlo, D.C. to treat the patient noted above:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I have reviewed the medical history stated above and certify it to be true and accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date Signed: _____

ASSIGNMENT TO PAY CLAIMS DIRECTLY TO DOCTOR

To (Attorney, Insurer, Employer, Other): _____

A. In consideration of the chiropractic services rendered and to be rendered by Bruns P.A., I authorize the direct payment of benefits to Dr. Erika K. Bruns Montemerlo, D.C. in the amount of any sum I now or hereafter owe by my attorney or out of the proceeds from any settlement of any liability case or by any insurance company obligated to make payment to me or PURE Center for Integrated Health based in whole or in part for upon the charges made for her services.
B. If a liability claim exists and my attorney/carrier refuses assignment, I acknowledge full financial responsibility for payment of my bill.
C. I further agree that this Authorization and Assignment is irrevocable until all monies owed to PURE Center for Integrated Health, are paid in full.

Patient/Guardian Signature_____ Date Signed: _____

CONSENT TO SERVICES AND PRIVACY PRACTICES

PAYMENT AND INSURANCE

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Patient Initials _____

CONSENT TO TREATMENT OF A MINOR CHILD

I authorize the licensed doctor and whoever she may designate as assistant to administer care as deemed necessary to my
(Relationship) _____ (Name)_____Patient Initials _____

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CONSENT TO SERVICES AND PRIVACY PRACTICES (continued)

FEMALE PATIENTS

This is to certify that to the best of my knowledge I am NOT pregnant and that PURE Center for Integrated Health has my permission to take x-rays. Beginning date of your last menstrual period _____ **Patient Initials _____**

PATIENT'S RIGHTS

PURE Center for Integrated Health respects the unique differences of our patients and will ensure that health care ethics are maintained for all patients' behalf.

1. The patient has the right to considerate and respectful care and is encouraged to obtain from the doctor relevant, current and understandable information concerning diagnosis, treatments and prognosis.
2. The patient has the right to know the identity of the doctor and office staff involved in their care.
3. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the consequences of this action.
4. The patient has the right to every consideration of privacy and should expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is required by law.
5. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options. **Patient Initials _____**

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of PURE Center for Integrated Health which describes the Practice's procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. **Patient Initials _____**

DISCLOSURE & CONSENT TO CHIROPRACTIC ADJUSTMENTS, CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I, _____, the undersigned patient, hereby request and consent to the treatment(s) including various modes of physical therapy, diagnostic x-rays, physical rehabilitation exercises, chiropractic adjustments and any other chiropractic procedures provided by the Doctor of Chiropractic, **Dr. Erika K. Bruns Montemerlo, D.C.** and/or other licensed Doctors of Chiropractic working at this clinic or office who now, or in the future, treat me while employed by, working with, or serving as back up for Dr. Erika K. Bruns Montemerlo, D.C.

I have had the opportunity to discuss with the Doctor of Chiropractic named above, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand that my condition may necessitate modification from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and herby consent to any similar subsequent treatment(s) or exam(s). If I do not consent I will immediately inform the clinic staff.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

There are times when individuals other than the clinic staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name:_____ Signature Patient/Guardian:_____Date:_____

To be completed by doctor or staff witness: Initials of Office Staff:_____ Date Signed:_____

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UNINSURED AND INDERINSURED PAYMENT AT TIME OF SERVICE POLICY

UNINSURED PATIENTS:

Patient's who do not have health insurance now have the option of saving 15% on all chiropractic fees incurred with Dr. Bruns. Payment must be received at the end of each visit or after the last scheduled weekly visit.

For instance, if your treatment plan calls for treatment on Monday and Friday, the outstanding balance for the week must be paid by Friday.

Payments may be made by: CASH or CHECK

UNDERINSURED PATIENTS: - ANNUAL DEDUCTIBLES OVER $500.00

Patient's who have health insurance policies with a deductible (out of pocket expense) of $500.00 or more, (which has not been met) may elect to pay at time of service or during your last scheduled weekly visit.

If you're insurance policy DOES NOT require our office to submit your claim for you*, you may take advantage of a timely payment discount of **15% including any applicable payer discounts**.

* Anthem, Cigna and Aetna require that we submit the claim for you and do not allow you to submit the claim yourself; therefore, the 15% discount is reduced by the cost of submitting and processing your claim, which is 5%.

For that reason, the eligible discount for any plan requiring provider claim submission is **10%**.

Payments may be made by: CASH or CHECK

No discount will be available on any outstanding balance remaining at the end of the month.

If you have any questions, please feel free to discuss this program with our staff.

If you have read and understand the information on this page please sign and date in the space provided below.

Print Patient's Name: _____Patient Signature: _____ Date: _____

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HEALTH CARE INFORMATION

Primary Care Provider:_____ Office Location:_____ Phone:_____
Was this visit pre-approved? Yes No

Other Provider:_____ Office Location:_____ Phone:_____
Was this visit pre-approved? Yes No

Other (i.e. Worker's Comp, Attorney, etc.):_____ Office Location:_____
Phone:_____ Was this visit pre-approved? Yes No

Medical Records Release: By signing below, I authorize Dr. Bruns and her staff to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed above for the purpose of insuring I receive proper treatment.

Print Patient's name:_____ Today's Date:_____

Patient or Guardian's signature: _____Patient's Date of Birth: _____

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Mainecare/Medicaid Services

Our Office will bill Mainecare/Medicaid directly for services rendered in this office that Mainecare covers as explained below.

Mainecare will only pay for services it determines to be medically necessary and only for treatment of the spine. Extremities are not covered under the Medicaid program.

Mainecare will only cover the following services:

1. A maximum of (2) x-rays per year
2. Chiropractic manipulation of the spine

Mainecare will only pay for a limited number of treatments per year. Mainecare requires an initial examination and re-examination at 6 months and 12 months which the Mainecare recipient is responsible to pay for.

Mainecare patients will be responsible for the following services or fees NOT covered by Mainecare (if applicable)

1. Mainecare Co-pay each visit (if applicable) $1.00-$3.00 per visit
2. Initial examination, required by Mainecare, but not paid for by the program (generally between $80.00 and $160.00)
3. Physio-therapy $20.00 per modality

I have read and understand the information above and I further understand that I will be responsible for the balance not covered by Mainecare.

Patient Signature: _____ Date:

PAYMENT AGREEMENT

I agree to make partial payments of $ _____ each visit/ weekly.

Patient Signature: _____ Date: