Dr. Richard Picard
CHIROPRACTIC CARE
Natural. Nontoxic. Smart.

WELCOME TO OUR OFFICE

Name:_____Date:_____

Address:_____City:_____

State:_____Zip:_____ Home Phone:_____

Age:_____Birth Date:_____ Occupation:_____

Marital Status (circle one) M S D W Spouse Name:_____

Cell Phone:_____E-mail:_____

Employed By:_____ Work Phone:_____

Health Insurance:_____ Policy #:_____

Insured Name:_____ Insured's Birth Date:_____

Insured's Employer:_____

Medical Doctor:_____City/Phone:_____

In case of emergency, whom should be notified?_____ Phone:_____

How did you hear about us? _____

I hereby give permission to the doctor to release any information requested by my insurance company.
I hereby authorize and direct my insurance benefits to be paid directly to the doctor.
I am financially responsible for all non-covered services, deductibles and co-payments.
I give permission to opt in for text message reminders and email correspondence.
I hereby give my permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.
I understand that just as there is a risk in all medical procedures, although rare; cervical spine manipulation can cause vertebral artery injury (stroke) in 1/500,000 cases.

By signing below I have read and agree to the above statements.

Print Name:_____

Signature:_____Date:_____

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New Problem Questionnaire

Name: _____ *Date:* _____

What is the nature of the problem you would like to address?

_____

When did the problem begin? _____ Days / Weeks / Months / Years ago

How did the problem start? (Circle one) Suddenly Gradually

What do you think caused this problem?

_____

Is this a work-related injury? Yes No

Is this related to a motor vehicle accident? Yes No

Have you had X-rays or MRI for this problem? Yes No

If yes: When: _____ Where: _____

What makes it feel better?

What makes it feel worse?

Have you taken pain medication for this issue? Yes No

How has this problem affected your daily life?

Have you seen another doctor or received treatment for this problem? Yes No
If yes, what type of treatment did you receive and did it help?

_____

_____ _____

Signature Date

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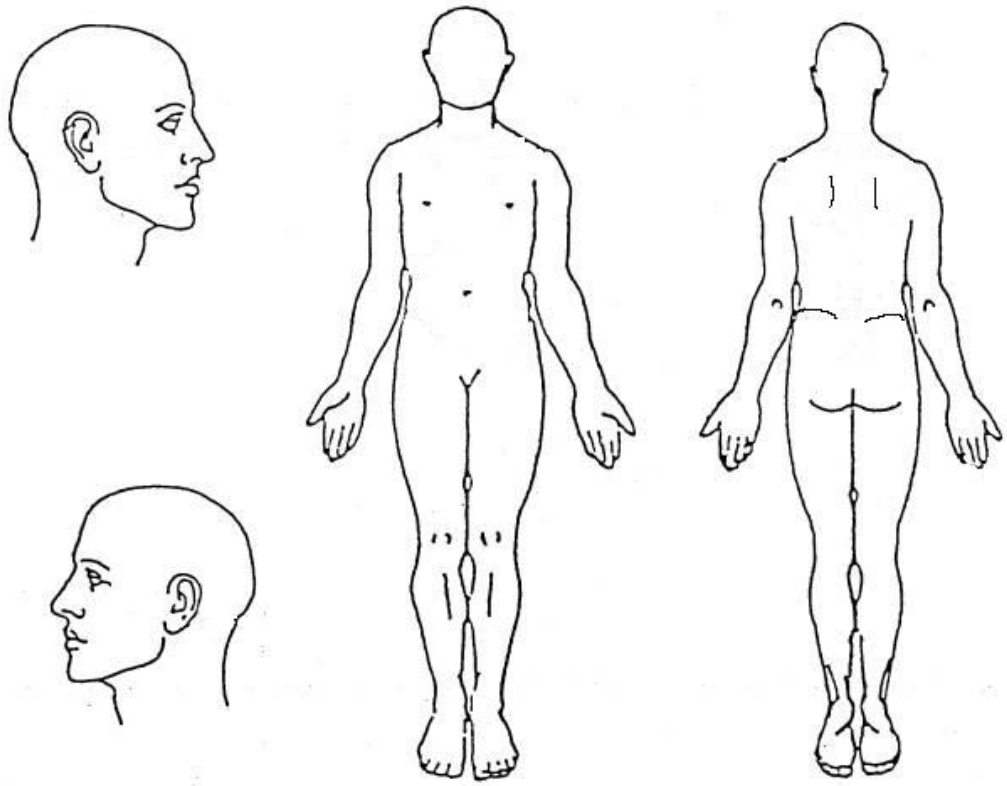
The line below represents the intensity of your pain. Please mark an "X" at the position on the scale which indicates how much pain you feel at this time.

No pain **Worst pain**

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Include all areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - -	oooooooooooo	xxxxxx	******	///////////



Name_____Date_____File_____

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Name: _____ Date: _____ File # _____

Confidential Health History

The items below may relate to your current condition. Mark (Y) if any of the following items pertain to you.

General Health Status

_____ Loss of sleep
_____ Anxiety / Nervousness
_____ Fatigue
_____ Weight gain
_____ Weight loss
_____ Fever / Chills
_____ Night Sweats
_____ Allergies
_____ Anemia
_____ Diabetes
_____ Cancer
_____ Thyroid disease
_____ HIV (AIDS)
_____ COVID-19
_____ Epstein Barr Virus (Mono)
_____ Lyme disease
_____ Autoimmune disease

_____

ENT

_____ Poor Vision
_____ Eye Disease
_____ Hearing Loss / Fullness
_____ Ear Infections / Tinnitus
_____ Vertigo / Meniere's
_____ Sinus Problems / Infections
_____ Dental Problems / Root Canal
_____ Hoarseness
_____ Sore Throat
_____ Tonsillectomy

_____

Gastrointestinal

_____ Poor digestion or appetite
_____ Difficulty swallowing
_____ Current Nausea
_____ Stomach or abdominal pain
_____ Ulcer or GERD
_____ Liver Disease
_____ Gall bladder Disease
_____ Diarrhea or Constipation
_____ Celiac Disease (gluten)
_____ IBS, Diverticulitis, Chron's
_____ Hernia
_____ Hemorrhoids
_____ Appendicitis

Respiratory

_____ Difficulty breathing
_____ Chronic cough
_____ Asthma
_____ Bronchitis
_____ Pneumonia
_____ Tuberculosis
_____ Excessive phlegm
_____ Emphysema
_____ COVID-19

_____

Cardiovascular

_____ Cardiovascular Disease
_____ Artery Disease (CAD)
_____ Irregular heart beat
_____ High blood pressure
_____ Ankle swelling
_____ Stroke
_____ Stent
_____ Pacemaker
_____ Blood Lipids (cholesterol)

_____

Skin

_____ Acne
_____ Psoriasis / Eczema
_____ Hives / Rashes
_____ Itching
_____ Bruising easily
_____ Melanoma / skin cancer

_____

Men Only

_____ Prostate problems
_____ Low Testosterone
_____ Testicular Cancer
_____ Urinary problems

_____

Women Only

_____ Hormone Replacement (HRT)
_____ Menopause / Hot flashes
_____ PMS
_____ Painful periods
_____ Irregular cycles
_____ Birth control pill
_____ Urinary / Yeast Infections
_____ Hysterectomy
_____ Breast augmentation

Neurologic

_____ Headache / Migraine
_____ Dizziness
_____ Fainting
_____ Weakness
_____ Numbness or tingling
_____ Burning sensation
_____ Arm or Leg pain
_____ Psychological disorder
_____ Neurological disease
_____ Epilepsy / Seizures

_____

Musculoskeletal

_____ Neck pain or stiffness
_____ Back pain or stiffness
_____ Joint pain or stiffness
_____ Swollen joints
_____ Muscular pain or tightness
_____ Arthritis
_____ Scoliosis / spinal curvature

_____

Exercise

_____ None
_____ Less than 3X per week
_____ More than 3X per week

_____

Lifestyle Habits

_____ Smoking
_____ Coffee/Caffeine
_____ Alcohol
_____ Recreational drug use

_____

Family History (List Mother/Father)

_____ Heart Disease
_____ High Blood Pressure
_____ Cancer
_____ Diabetes
_____ Thyroid Disease
_____ Other _____

_____

List All Medications Here

_____
_____
_____
_____
_____

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Signature On File

- I authorize the release of records requested by my insurance company acquired in the course of my examination and treatment
- If involved in a personal injury such as a car accident I authorize the release of records to the insurance companies that request my records
- I authorize the release of records and reports to my medical doctor
- I authorize the use of this signature on all insurance forms
- I authorize and direct my insurance benefits to be paid directly to the doctor
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance
- I am financially responsible my co-payments, deductibles and non-covered services
- I am financially responsible for any office visits my insurance company denies
- I hereby give my permission to the doctor to administer treatment and perform procedures, as he may deem necessary in the diagnosis and treatment of my condition.
- I understand that just as there is a risk in all medical procedures, although rare; cervical spine manipulation can cause vertebral artery injury (stroke) in 1/500,000 cases.

By signing below I have read and agree to the above statements.

Print Name:_____

Signature:_____Date:_____

342 Atwood Avenue Cranston, RI 02920 401.942.6967

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PRACTICE POLICY AGREEMENT AND CONSENT
for Chiropractic Services

To the patient: You have the right, as a patient, to be informed about the policies of the practice of Dr. Richard E. Picard, so you can make an informed decision whether to proceed with treatment at this facility. This policy agreement is a communication effort to make all our patients better informed about the operations and procedures of our office.

1. Payment: An insurance co-payment or cash visit payment is required at the time of service.

2. We are out-of-network for United Healthcare, Tufts, Aetna, Cigna, Optum, Neighborhood and Medicare. This means that you can still receive chiropractic care at our out-of-network fee which is $130 for the initial new patient visit and $65 for each additional visit. If you are an existing patient and haven't been seen in over a year or have a new problem that needs extra attention, you will be charged for a comprehensive exam visit; $95.

3. Insurance Benefits: We are in-network for Blue Cross. We do our best to keep track of your insurance benefits; however, knowing your insurance benefits (deductible, co-payment, and visit allotment) are your responsibility. You must notify us when you change your insurance plan so we can process your claim correctly. If you do not notify us of a plan change, your claim will go unprocessed. We are not responsible for any unpaid claims that may have resulted from this; thus, it is your responsibility to pay for any outstanding claims. If you had chiropractic care elsewhere, please inform us as this will impact your visit allotment for the year.

4. Missed Office Visits: A 24-hour notice of cancellation is required for all appointments. If 24-hour notice is not received prior to your appointment, you will be responsible for a $25 missed appointment fee. We have an e-mail reminder that goes out 2 days prior to your appointment and a text reminder that is sent 2 hours prior to your appointment. This is a courtesy service and is not meant to replace an appointment card. It is ultimately your responsibility to keep track of your appointments. We are not responsible for e-mails or texts that you may or may not have received. We encourage you to take an appointment card. The policy stands that if you miss your appointment, you will be charged $25.

5. Returned Checks and Chargebacks: A $30 processing fee will be charged for returned checks / chargebacks.

6. Extended Treatments: Laser Therapy, Muscle Stim, and/or Ultrasound are considered extended treatments: An additional $20 per session is charged if any of these are used as an adjunct to your treatment.

7. Extended Services: Anything other than spinal manipulation such as TMJ, carpal tunnel, knee/shoulder/hip/foot issues, etc., are an extended service. Your insurance company will not pay for anything other than spinal manipulation. An additional $20 per session is charged for any treatment area other than the spine.

8. Medicare: If you are 65 years or older, your coverage automatically changes to CMS Government (Federal) coverage called Medicare. We do not participate in Medicare and thus cannot accept your health insurance.

9. Workers Compensation: Any injury occurring at work is workers compensation. Your health insurance will deny your visits if it is work related, but your company's insurance should cover your visits. Please inform us promptly within 3 days of the injury if you were injured at work.

Initial First Page _____

10. Personal Injury: Any injury occurring as a result of a motor vehicle accident will be denied by your health insurance. You are covered by your car insurance. If you have been injured because of a car accident and/or if you have retained an attorney, it is your responsibility to disclose this information and notify us prior to being seen.

11. Emergency visits: An emergency visit is any visit requested on the same day where there is no availability in our schedule, or when the office is normally closed. You are responsible for the normal session fee plus an additional emergency visit fee of $130.

12. Nutrition: Nutrition consultations are kept separate from chiropractic appointments. Please feel free to schedule a private appointment at the front desk.

13. No fragrance policy: Some of our patients have chemical sensitivities. Wearing perfume or cologne in the office is enough to cause an allergic response with sensitive individuals. Please avoid wearing fragrance to your appointment.

14. COVID-19 and FLU policy: Our office relies on CDC and state guidelines for COVID-19/viral outbreaks. If you have a cold or the flu, please either wear a mask or reschedule your appointment to keep everyone safe.

15. Accounting: Insurance companies are governed by Federal and State regulations regarding claim processing. Occasionally we have experienced delays in payment requiring re-submission to the insurance company. We do our best to file your claim in a timely fashion at the end of each business week. If for some reason your insurance company denies your claim or is unresponsive to our claim submission, we will gladly re-submit it for you one time, and follow-up with the insurance company on your behalf. Once your claim is re-submitted, we are not responsible for further insurance denials or unresponsive actions by the insurance company and thus you agree to pay the remaining balance owed to us. We will not carry a balance that is delinquent over $100. You will be required to pay your outstanding balance that is due to us. We are not responsible for maintaining a credit balance in your account that is over one calendar year old.

16. Form Fees: We reserve the right to charge for any form such as TDI, FMLA, office notes or any reports needed by other doctors and/or insurance agents. Our simple form fee such as TDI (1 sheet) is $10. FMLA form (less than 10 pages) is $25, Progress summary note $30, Chart notes and records 10-50 pages is $50, Professional Doctor/Lawyer is $150. Report fees are subject to change and are based on the time and complexity of the case.

17. Online Virtual Technology: We are not responsible for any technological breach of private health information and/or personal data from all online technology that is used by this office.

I have fully read and understand the above information. My initials above and signature below indicates my full informed consent to this practice policy. I wish to proceed with my visit and the recommended therapy.

_____

(Print your name) Date

_____

(Sign your name) Date