CONCORD HEALTH CENTER

56 Winthrop Street
West Concord, MA, 01742
Phone: 978-369-2266
Fax: 978-369-5205
www.concordhealthcenter.com

PATIENT INSTRUCTIONS
We ask patients to arrive 15 minutes before your appointment time to prepare for your visit. Please print the new patient forms and fill them out before your visit. This will cut down on wait time and preparation time. These forms can be found on our website.

PARKING
There is plenty of free parking in the front of the building. If you need directions please feel free to call us at 978-369-2266.

HOURS OF OPERATION	URGENT CARE
Monday: 9:30am- 4:00pm	Monday: 4:00pm- 5:00pm
Tuesday: 9:00am-12:00pm 4:30pm- 8:00pm	Tuesday: 12:00pm- 1:00pm
Wednesday: 9:30am-4:00pm	Wednesday: 4:00pm- 5:00pm
Thursday: 9:00am-12:00pm 4:30pm-8:00pm	Thursday: 12:00pm- 1:00pm
Friday: 7:30pm- 12:00pm	Friday: 12:00pm- 1:00pm
Saturday: 9:00am- 12:00pm	Saturday: 12:00pm-1:00pm

MRI'S OR X-RAYS
If you have any recent MRIs done in the year prior to your visit please bring them to your appointment. CD copies are preferred over films of the MRIs or X-rays.

URGENT CARE SLOTS
We have urgent care hours every day which we don't schedule until the same day.
You can either call the office and leave a message before 8 AM, on the urgent care line, or email us before 8 AM and leave us an email message. We generally check the emails before the voicemails. If you want to wait until the staff is in, and speak with them directly you can call the office between 8:30 AM and 9:00 AM. There is a $15 surcharge for services rendered during the urgent care hour, this surcharge must be paid before any urgent services are rendered.

INSURANCE REFERRALS
If your insurance requires a referral to see a specialist, your are responsible for obtaining it from your primary care physician prior to your appointment and making sure we receive it. If we have not received the referral, you will be asked to sign a waiver stating that you are aware that you are being seen without a referral and no further appointments or diagnostic tests will be scheduled. Please fax all referrals to the Concord Health Center at 978-369-5205.

CO-PAYMENTS
If your insurance requires a co-payment it is due at the time of your appointment. We accept payment in the form of credit cards, personal checks, and cash. It is not unusual for bills to change once they have been processed through insurance. If you have any questions about insurance coverage or billing please call us at 978-369-2266.

PATIENT HISTORY & ASSESSMENT

PATIENT INFORMATION				
Patient's Last Name :	First:	Middle:	DOB:	Age:
Preferred contact number: ( )	Secondary phone number: ( )			
Mailing Address:				
E-Mail Address:				
Marital Status:	Student Status:	Weight:	Height:	
Insurance Subscriber name:	Subscriber DOB:			

PRIMARY CARE PHYSICIAN			
Name:	Address:	Phone:	Fax:

REFERRING PHYSICIAN			
Name:	Address:	Phone:	Fax:

HISTORY OF YOUR PAIN/SYMPTOMS

What are the main problem(s) you would like help with?

When did your symptoms start?

Please indicate where your pain/symptoms were initially located (ex. Neck, lower back)

What would you say your symptom ratio is?
% Spine % leg % arm (ex. 75% spine, 25% leg)

CIRCLE THE BEST ANSWER

1. What event(s) led to your original Symptoms**?**

Accident Cancer Work Injury No obvious cause Following an operation

Other:____

2. Since the time of onset, my symptoms have:

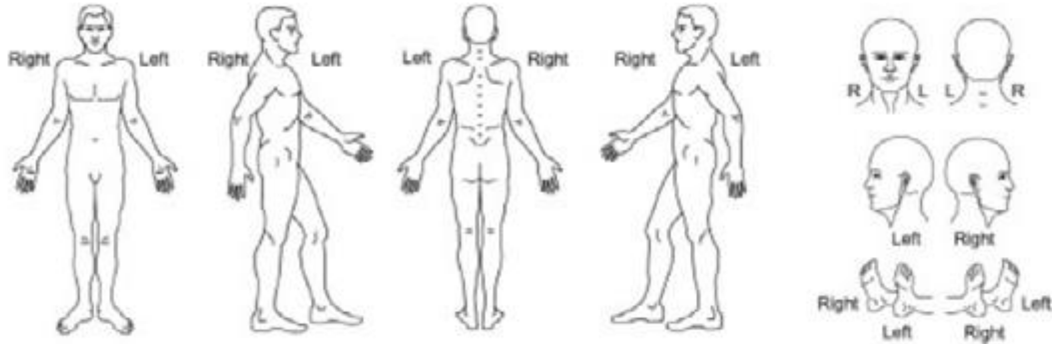
Remained the same Became more severe Lessened in severity

ACTIVITY

(Check the appropriate amount of time you can perform the following activities)

	Unable	15 minutes	30 minutes	45 minutes	60 minutes	Indefinitely
Sit						
Stand						
Walk						

PAIN DIAGRAM
(On the body diagram below indicate where your pain is located)



DESCRIPTION OF CURRENT PAIN

Date of current onset	**Pain frequency**	**Pain is worse**	**Your tolerance to pain**
/ /	❑ Constant ❑ Comes and Goes	❑ Morning ❑ Afternoon ❑ Evening ❑ Night	❑ Low ❑ Average ❑ High

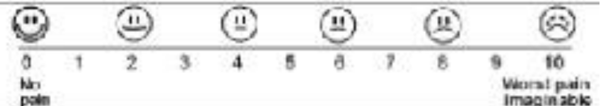
Description of Pain(Check all that apply)

❑ Ache ❑ Dull ❑ Sharp ❑ Sting ❑ Tingle
❑ Burn ❑ Deep ❑ Superficial ❑ Swelling ❑ Throb
❑ Other (please describe)

What Relieves Pain (Check all that apply)

❑ Rest ❑ Cold ❑ Relaxation Technique ❑ Exercise
❑ Sleep ❑ Heat ❑ Repositioning ❑ Massage
❑ Other (please describe)

On a scale of 0 to 10 with 0 being no pain and 10 being the highest rate your pain now (Circle One)



When I have pain it makes me feel (**Check all that apply**)

❑ Sad ❑ Angry ❑ Anxious ❑ Tired ❑ Helpless
❑ Other (please describe)

What Makes Pain Feel Worse

What Makes Pain Feel Better

Patient Signature/Person Completing Form **Date** **Time**

PREVIOUS TREATMENTS

(Check and treatments you have tried for your current problem)

Treatment	Date	Did it help?	Treatment	Date	Did it help?
Nerve Blocks		❑ No ❑ Yes	Physical Therapy		❑ No ❑ Yes
Acupuncture		❑ No ❑ Yes	Psychotherapy		❑ No ❑ Yes
Chiropractor		❑ No ❑ Yes	Injections		❑ No ❑ Yes
Massage		❑ No ❑ Yes	Surgery		❑ No ❑ Yes
Brace/Collar		❑ No ❑ Yes	Other (specify)		❑ No ❑ Yes

PREVIOUS DIAGNOSTIC TESTING (Please enter any testing performed for your current problem)

Test	Date	Test	Date
MRI		Myelogram	
CT Scan		EMG/NCV	
X-Ray		Bone Scan	
Discogram		Other (specify)	

PAST MEDICAL HISTORY

(Check all that apply)

❑ High Blood Pressure	❑ High Cholesterol	❑ Diabetes	❑ Liver disease
❑ Heart Disease	❑ Sleep Apnea	❑ Seizures	❑ Cancer
❑ Asthma	❑ Bleeding problems	❑ Kidney disease	❑ Other ____________

PAST SURGICAL HISTORY

Year	Describe	Hospital	Doctor

CURRENT MEDICATIONS

(List all medications you are currently taking including prescribed, over-the-counter, herbs and vitamins)

Medication Name	Dose/Frequency	Started	Prescribing MD

REVIEW OF SYSTEMS
(Check all that apply)

CONSTITUTIONAL
◯◯ Weight loss
◯◯ Loss of appetite
◯◯ Fatigue
◯◯ Fever, chills or sweats
◯◯ Recent Infections

EYES
◯◯ Blurred/double vision
◯◯ Eye pain or irritation
◯◯ Dry eyes
◯◯ Failing vision

EARS, NOSE MOUTH AND THROAT
◯◯ Difficulty hearing
◯◯ Ringing in ears
◯◯ Dry mouth
◯◯ Difficulty swallowing
◯◯ Frequent sore throat
◯◯ Frequent nose bleeds
◯◯ Sinus trouble
◯◯ Congestion

CARDIOVASCULAR
◯◯ Heart murmur
◯◯ Chest pain
◯◯ Palpitations
◯◯ Shortness of breath
◯◯ Swollen ankles

ENDOCRINE
◯◯ Cold hands/feet
◯◯ Thyroid Problem

RESPIRATORY
◯◯ Cough
◯◯ Wheezing

GASTROINTESTINAL
◯◯ Nausea or vomiting
◯◯ Diarrhea
◯◯ Constipation
◯◯ Abdominal pain
◯◯ Ulcers
◯◯ Heartburn
◯◯ Jaundice (yellow skin)
◯◯ Black or bloody stools

GENITOURINARY
◯◯ Frequent urination
◯◯ Pain with urination
◯◯ Blood in urine
◯◯ Bladder accidents
◯◯ Incontinence
◯◯ Kidney infection
◯◯ Kidney stones
◯◯ Bladder infections
◯◯ Erectile dysfunction

MUSCULATURE
◯◯ Back pain
◯◯ Joint pain
◯◯ Joint swelling
◯◯ Muscle stiffness
◯◯ Arthritis
◯◯ Osteoporosis

INTEGUMENTARY (SKIN)
◯◯ Rash/ Sores
◯◯ Eczema
◯◯ Itching/ burning
◯◯ Acne

NEUROLOGICAL
◯◯ Headaches
◯◯ Loss of strength
◯◯ Weakness
◯◯ Numbness
◯◯ Fainting spells
◯◯ Dizziness/ Vertigo

PSYCHIATRIC
◯◯ Difficulty sleeping
◯◯ Anxiety/ Depression
◯◯ Mood Swings
◯◯ Memory loss

GYNECOLOGICAL
◯◯ Painful periods
◯◯ Painful intercourse
◯◯ Pregnant
◯◯ Post-menopausal
◯◯ Last menstrual period date:________

SOCIAL HISTORY

What is your occupation?

Working Status:

❑ Full Time ❑ Part Time (__ hours per week) ❑ Homemaker ❑ Retired _____ Years

❑ Unemployed ______ years due to pain ❑ Unemployed ____ years due to _________

How would you classify your occupation:

❑ Sedentary ❑ Light ❑ Medium ❑ Heavy

Are you on disability? · Yes · No	**Date Started:**	**Reason:**

Marital Status (please circle one) Divorced / Life Partner / Married / Single / Widow / Separated

Do you have any children? If so what ages:	❑ No ❑ Yes
Do you have any spiritual or cultural practices that you would like us to include in your care today?	❑ No ❑ Yes
Do you have any trouble understanding written or verbal instructions?	❑ No ❑ Yes
Have you had any difficulty caring for yourself at home over the last 3 months?	❑ No ❑ Yes
Is anyone in your personal life hurting you or making you feel unsafe?	❑ No ❑ Yes
Have you had a significant unexplained weight change (>15 pounds) in the last 3 months?	❑ No ❑ Yes
Have you experienced significant stress this past year? If yes, please explain:	❑ No ❑ Yes
Do you have any pending health related litigations?	❑ No ❑ Yes

BEHAVIORAL HEALTH

Do you smoke? If yes how much:	❑ No ❑ Yes
Do you drink more than **two** alcoholic beverages per day on a **DAILY** basis?	❑ No ❑ Yes
Do you use street drugs/narcotics? If yes, please explain:	❑ No ❑ Yes

FALL RISK ASSESSMENT

Have you fallen in the last (6) months (not a slip or a trip)?	❑ No ❑ Yes
Are you feeling weak, dizzy, or lightheaded today?	❑ No ❑ Yes
Do you need help to walk or change your clothes?	❑ No ❑ Yes
Have you ever experienced lightheadedness or dizziness before or after having your blood drawn or having an IV started?	❑ No ❑ Yes

FUNCTIONAL STATUS

Do you use? ❑ Cane ❑ Walker ❑ Braces ❑ Wheelchair ❑ None of these

Do you exercise? ❑ No ❑ Yes If so what type:

How many days per week do you exercise?

How long do you exercise each time (on average)?

CONCORD HEALTH CENTER
INFORMED CONSENT FORM FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures to be performed on myself, or the patient named below, for whom I am legally responsible. This includes, but is not limited to examination tests, diagnostic x- rays and physiotherapy techniques which are recommended by Dr. Jeffrey Robichaud who will be rendering treatment to me.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These include, but are not limited to, fractures, dislocations, muscle strains, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and joint separations. Some forms of cervical manipulation have been associated with injuries to the arteries of the neck leading to or contributing
to serious complications- including stroke. This is a very rare occurrence, estimated at 1:3,000,000. We screen our patients for contrainidcations to cervical manipulation to the best of our ability.

I DO NOT expect Dr. Robichaud to be able to anticipate all of the risks and complications. I do expect the Doctor to exercise good judgment during the course of care performing procedures which are in my best interest in both safety and efficacy.

I have read, or have had read to me, the above explanation of chiropractic adjustments and related therapies. By signing below, I am stating I have weighed the risks involved in undergoing treatment, and have decided in favor of moving forward with care. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent to cover the entire course of care for my present condition and for future conditions for which I seek treatment.

Printed name of patient: ____
Signature of patient: ____
Signature of Patient's Representative: ____
Date: ____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to use and disclose my private health information: By signing this form I give Dr. Jeffrey Robichaud permission to use/disclose my private health information for the purposes of carrying out treatment, obtaining payment for services rendered or for routine office operations related to my care.

2. Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Dr. Jeffrey Robichaud will not be able to provide me with any treatment until such time that I agree to sign. However, in the event of an emergency where Dr. Jeffrey Robichaud is required by law to render emergency care my consent is not required.

3. Right to review notice of privacy practices: Dr. Jeffrey Robichaud has provided me the opportunity to review the privacy practices of the office regarding the disclosure of protected health information.

4. Changes to the privacy notice: Dr. Jeffrey Robichaud may change the notice of privacy practices as needed. I may obtain a copy of the revised practices by contacting the office directly.

5. Right to request restrictions on use/disclosure of information: I have the right to request that Dr. Jeffrey Robichaud restrict the use of protected health information for the purposes of treatment, payment or operations. However, I understand Dr. Jeffrey Robichaud is not required to agree to these requested restrictions. This request must be made in writing and Dr. Jeffrey Robichaud will give a written reply to my request within 48 hours of it’s receipt.

6. Right to withdraw consent: I have the right to withdraw this consent at any time. I must do so in writing. My withdrawal of consent does not impact information disclosed or used prior to the request for withdrawal. If I withdraw my consent I understand Dr. Jeffrey Robichaud will no longer be able to provide me with treatment, unless required by law for emergency purposes.

7. Effective period: This consent is good from this date forward, unless I withdraw my consent in writing.

8. References to “I” and “me”: References to “I” and “me” in this document include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, such as a minor child, it is because I am the legal guardian, parent of agent under an active power of attorney. I acknowledge I and legally authorized to sign this consent on behalf of the individual.

Patient name: ____
Signature: ____
Name of individual if other than the patient ______________________________
Date:____

DR ROBICHAUD IS IN NETWORK FOR THE FOLLOWING INSURANCE CARRIERS (If you plan on submitting your visits to one of the carriers below please find, read, sign, and date the appropriate policy waiver located on our website)	
1.	**HARVARD PILGRIM**
2.	**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS**
3.	**TUFTS HEALTH PLAN**
4.	**TUFTS MEDICARE PREFERRED (WILL NEED REFERAL FAXED OVER FROM PCP)**
5.	**MEDICARE/MEDEX**

***If your insurance carrier is one of the above**, it **doesn't guarantee that you have chiropractic coverage**, every plan is different. If you're unsure please call your insurance carrier to determine whether your services will be covered. Also keep in mind that you may have a deductable that needs to be met before utilizing your coverage and benefits for chiropractic.

Dr Robichaud is out of network for **United Health Care and **Cigna Health Insurance**. If you have out of network benefits and would like us to submit your visits please fill out the **Harvard Pilgrim policy waiver for United** and the **Tufts policy waiver for Cigna.**

***Some plans purchased through the Massachusetts Exchange utilize a Mass Health network, Dr Robichaud is **out of network for Mass Health**. If you have purchased your plan through the exchange we strongly suggest contacting your insurance company to determine if your services with Dr Robichaud will be covered. **If your plan is a combination of two or more insurance companies** we also recommend you call your insurance carrier to determine chiropractic coverage.

UNDERSTANDING PIP BENEFITS- MOTOR VEHICLE ACCIDENTS

In Massachusetts we have no fault benefits when it comes to injuries sustained in an automobile accident. This means that YOUR auto insurance company pays for your medical bills even when the accident is the other driver's fault. Most insurance policies carry Personal Injury Protection (PIP) benefits which will cover your initial $2000 of medical expenses. This includes transportation by ambulance, emergency room assessment, diagnostic testing and doctor's visits. These charges are paid at 100% by your insurance company- with no cost to you. We will ask you for your PIP information and file your claims directly to your auto insurance carrier.

If your injuries result in the need for care exceeding $2000 you will receive a formal PIP exhaustion letter from your auto carrier. This letter will be forwarded to your health insurance carrier to let them know you were injured in a motor vehicle accident and have been receiving treatment. Your health insurance carrier will then be responsible for processing and paying your claims under the terms of your normal health insurance coverage. This may include deductibles, co payments and limitations in covered services. We will file your claims directly to your health insurance carrier.

If there is a remainder balance due after your health insurance carrier processes and pays your claim, we will forward you a bill. You will be asked to pay the bill, and we will give you a receipt. You can forward this receipt to your auto insurance carrier and they will reimburse you for any out of pocket expenses related to treatment of accident related injuries. We do not forward remainder balances back to your auto insurance carrier for coordination of benefits once PIP is exhausted.

If you sustain injuries which result in medical expenses exceeding $2000 you have the option to pursue filing a law suit against the at fault party and their insurance company. In most cases that will require the use of an attorney. With your permission, we will forward all of your office notes along with your bills to your attorney so they can have a record of your treatment and expenses. It is important to understand that treatment under a PIP claim is solely for the treatment of injuries sustained as a direct result of your accident. It is the responsibility of the auto insurance company to return you to your pre accident state of health and functioning. Once you have reached that status, as determined by Dr. Robichaud, you will be discharged from treatment under your PIP claim. You can continue to receive treatment here in the future on an as needed basis under your normal health insurance coverage.