WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City_____State_____Zip_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) _____ **DATE** _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _____ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 ____.

X_____
(patient signature)

_____
(please print patient name)

X_____
(signature of Guardian if applicable)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of _____.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date
X_____ _____
Witness (Office Staff) Date

Review of Systems

Name_____ **Date**_____

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Please check ALL options you have previously tried to assist in above symptoms:

____Over the counter medications
____Prescriptions
____Dietary Changes
____Exercise
____ Consult with specialist
____ Supplements
____ Alternative medication/treatment therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Y or N
If yes, what?_____ When?_____

Health Questionnaire

Name: _____DOB: _____ Home Phone #: _____ Work Phone #: _____

Address: _____City: _____ State ____Zip: _____

Occupation: _____# Hours/Week Currently Working:_____

E-mail Address: _____Cell Phone #: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain	☐ Tension Across Top of Shoulders	☐ Tired/Fatigued
☐ Pain between Shoulder Blades	☐ Numbness/Tingling in Arms/Hands	☐ Difficulty Sleeping
☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet	☐ Allergies
☐ Tension/Headaches	☐ Pain in the legs	☐ Digestive Problems
☐ Fibromyalgia	☐ Pain in the feet	☐ Carpal Tunnel

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
☐ Moody	☐ Decision making	☐ Lose patience with spouse/children
☐ Irritable	☐ Poor attitude	☐ Restricted household duties
☐ Interrupt sleep	☐ Decreased productivity	☐ Hinders ability to exercise or sports
☐ Restricted in your daily activities	☐ Exhausted at the end of the day	☐ Interferes with ability to do hobbies or other activities
	☐ Unable to work long hours	

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications…Helped: Little Some Much	◆ Exercise…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much	◆ Nutrition…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much	◆ Stretching…Helped: Little Some Much

OTHER _____

Location Date: Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ Date: _____/_____/_____

How did you hear about us? _____

Office Use Only: Date: _____ Time:_____ Screener:_____ Intake: Y / N Intake Type: _____ Location: CAN / WDK