Patient Intake

Date:____________________

First Name:_______________________ Last Name: _________________________

Address:____

City:______________________ State:___________ Zip Code:_________________

Cell Phone:_____________________ Home Phone:___________________________

Email:____

Date of Birth:_______________ Gender:______ Occupation:__________________

How did you hear about us? ____

Primary Care Physician's Name and Phone Number:__________________________

Emergency Contact Name and Phone Number:______________________________

Relationship to Emergency Contact: _____________________________________

Insurance Company Name:____

Primary Insured Name: ____

Primary Insured DOB:______________ Insurance ID:________________________

Reason for Visit:____

During what activity/motion did you first notice the pain?: ____________________

____

When did the symptoms Start? (est) :_____________________________________

Are your symptoms from a work injury or car accident?* Yes No

If yes, please notify the front desk to receive additional paperwork

Have you had (or are currently receiving) treatment for this condition? Yes No

If yes, where and when?____

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Have you recently been hospitalized? Yes No

If yes, when and why?____

Have you had a recent: X-Ray MRI CT EMG None

If yes, when and why?____

Pain Levels	Location
1. Hardly notice pain **2.** Notice pain, doesn't interfere with activities **3.** Sometimes distracts me **4.** Distracts me, can do usual activity **5.** Interrupts some activities **6.** Hard to ignore, avoid usual activities **7.** Focus of attention, prevents activities **8.** Awful, hard to do anything **9.** Can't bear the pain, unable to do anything **10.** Unbearable, going to ER	

Describe your pain by circling all that apply:

Constant Intermittent Sharp Dull Throbbing Aching

Burning Shooting Other____

Stress Level: High Moderate Low

Personal Health is Currently: Good Fair Poor

If poor, please explain:____

Does your current pain affect your ability to participate in normal roles and responsibilities (work, school, social activities, hobbies, parenting, etc.)?

Yes No

If yes, please explain:____

Allergies: Yes No

If yes, please list:____

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List all medications (prescription and non-prescription) currently taking:

____

List previous surgeries within the last 6-8 months (surgery, month/year format):

____

Check all the following that apply:

___Cancer	___Chemical Dependency	___Osteoporosis	___Heart Problems
___Thyroid Problems	___High/Low Blood Pressure	___Anemia	___Asthma
___Diabetes	___Multiple Sclerosis	___Hepatitis	___Stroke
___Arthritis	___Emphysema/Bronchitis	___Fibromyalgia	___HIV/AIDS
___Vertigo/Dizziness	___Contagious Disease	___Epilepsy/Seizures	___Depression
___Anxiety	___Headache/Migraine	___Sleep Disorders	___Varicose Veins
___Jaw Pain/TMJ	___Neck Pain	___Mid Back Pain	___Low Back Pain
___Bursitis	___Tendonitis	___Hypermobility	___Sinus Problems
___Bruise Easily	___Blood Clots	___Muscle Cramping	___Pulled Muscle
___Infectious Skin Conditions		___Swelling/Edema/Lymphedema	

Other:____

Are you currently pregnant? Yes No

If yes, when is your due date?______________________________

I certify, to the best of my knowledge, that the above information is true and correct.

______________________________ Patient/Guardian Signature

______________________________ Printed Name of Patient

______________________________ Date

______________________________ Guardian Relationship

Informed Consent for Treatment

Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by a Doctor of Chiropractic at Prime Sports Med.

I have had an opportunity to discuss with the doctor or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise,
of a cure for any symptom, disease or condition as a result of treatment in this clinic. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Accept Treatment: Patient Initials _____ **OR** **Decline Treatment**: Patient Initials _____

Massage Therapy

Massage therapy is a treatment modality designed for problems associated with the musculoskeletal system such as chronic muscle stiffness, loss of range of motion, chronic musculoskeletal pain, lymphatic retention and diminished bio-energy. Massage therapy is contraindicated under certain medical conditions. Because of this, it is absolutely necessary for clients to disclose their medical history to their massage therapist. My signature represents my complete medical disclosure and my understanding that massage therapy is not a substitute for a medical examination, diagnosis, or treatment.

I acknowledge that I have the right to decline any part of my treatment at any time before or during treatment, should I feel any discomfort or pain or have other unresolved concerns. It is my right to ask my massage therapist about the treatment they have planned based on my individual history, medical diagnosis, symptoms, and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

I have read this consent form and understand the risks involved in massage therapy and agree to fully cooperate, participate in all massage therapy procedures, and comply with the established plan of care.

Accept Treatment: Patient Initials _____ **OR** **Decline Treatment**: Patient Initials _____

Physical Therapy

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before I am asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict my response to a specific modality, procedure, or exercise protocol. Prime Sports Med does not guarantee what my reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that I am seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

I acknowledge that I have the right to decline any part of my treatment at any time before or during treatment, should I feel any discomfort or pain or have other unresolved concerns. It is my right to ask my physical therapist about the treatment they have planned based on my individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Accept Treatment: Patient Initials _____ **OR** **Decline Treatment**: Patient Initials _____

______________________________ Patient/Guardian Signature

______________________________ Printed Name of Patient

______________________________ Date

______________________________ Guardian Relationship

HIPAA Form
Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to patient,and “Provider” refers to Prime Sports Med (PSM) clinic.
I consent to the use or disclosure of my protected health information by the Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that analysis, diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider.

I have the right to revoke this consent, in writing, at any time, except that the Provider has taken action in reliance on this consent.
My “protected health information” means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for the Provider is also posted in the waiting room at Prime Sports Med. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

The Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Release of Confidential Communication of Protected Health Information

I, ____________________________________, give PSM permission to disclose medical information and/or test results to ____.

Please list the relationship to the patient: ___________________________________.

______________________________	______________________________
Patient/Guardian Signature	Printed Name of Patient
______________________________	______________________________
Date	Guardian Relationship

Financial & Attendance Policy

We strive to provide the highest quality health care while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

Patients WITH Insurance

Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, the following must be fully understood:

- It is your responsibility to notify our office if there are any changes in your insurance provider(s).
- You will be responsible for your deductible, coinsurance, denied charges, or copay. Payment is due at time of service.
- ***YOU MUST NOTIFY US IF PRE AUTHORIZATION IS REQUIRED***
- Your insurance is a contract between you and your insurance provider. *You are responsible for knowing your benefits*.Our office will not enter into a dispute with your insurance provider over policy limitations or issues. This is your responsibility and obligation. *All charges incurred are your full financial responsibility.*
- We cannot be certain if your insurance covers chiropractic care, physical therapy, or massage therapy, although most policies do provide some coverage. The amount they pay varies from one policy to another.
- We will call to check your benefits, however this is NOT a guarantee of payment or coverage. All charges incurred are your full financial responsibility. If your insurance denies any charges for any reason, you may be billed.

Patient Initials_____

Patients WITHOUT Insurance

We require that 100% of the examination and treatment be paid at the time of the visit. If you have any questions or concerns regarding this, please speak to our front desk staff PRIOR to your appointment. We accept cash, checks, or cards. No insurance will be billed.

Patient Initials_____

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Attendance Policy

While we are sensitive to the fact that an emergency may occur, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of all our patients. Accordingly, we must ask for your cooperation with the following policy:

- If you are more than 15 minutes late for your appointment, treatment will be canceled and a fee charged for missing the appointment.
- A scheduled appointment must be canceled at least 24 hours in advance, or a fee will be charged for that appointment.
- Failure to show up for an appointment (NO SHOW) will result in a fee being charged for that appointment.
- All patients, regardless of insurance/third party payor, will be charged a cancellation fee for each late canceled, or no-show appointment. **The patient is responsible for the fee not the insurance or third party payor.**

Pay at Time of Service Fees:
New Patient Chiropractic: $115-$300
Adjustment Only: $55-$150
Laser Only: $55
Laser Upgrade: $20
Sports Therapy: $89-$250
McKenzie session w/ Dr Field: $99-$250
New Patient Physical Therapy: $125-$225
Returning Patient Physical Therapy: $100-$200
60 Minute Massage: $85-$125

Patient Initials_____

Late Cancel Fees & No Show Fees:
Late Cancel Massage: $85
No Show Massage: $85
Late Cancel PT: $100-$125
No Show PT: $100-$125

Patient Initials_____

If I am unable to provide 24 hours' notice of cancellation I authorize Prime Sports Med to charge the credit card listed below. I understand this card will not be charged unless I fail to give the required 24 hours' notice.

Credit Card #____________________________________ Exp________CVC________ Zip________

____
Patient/Guardian Signature

____
Printed Name of Patient

____
Date

____
Guardian Relationship