Integrative Health and Rehabilitation

Chiropractic Wellness Center
It's more than feeling better... it's being healthier.

New Patient Welcome Packet

Patient Information

Name: _____
Last First MI Prefer to be called

Phone: _____ Email address: _____
Cell Work

Mailing Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

How would you like to receive appointment reminders? ☐ Phone ☐ Email ☐ Text

If choosing "Text" please tell us you Phone Provider (Verizon, AT&T, etc.): _____

May we send you our e-newsletter to inform you of special offers and health information? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____ Phone: _____

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? _____

Health History

What is your current weight: _____ lbs., and height: _____ ft. _____ in.

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Aids/HIV	☐ Chemical Dependency	☐ Goiter	☐ Measles	☐ Scarlet Fever
☐ Alcoholism	☐ Chest Pain	☐ Gout	☐ **Memory Loss**	☐ Severe Allergy to Chicken
☐ Allergies	☐ Chicken Pox	☐ **Hair Loss/Breakage**	☐ Mononucleosis	☐ STD
☐ Anemia	☐ Cold Feet	☐ Heart Disease	☐ Migraines	☐ Stomach Problems
☐ Anorexia	☐ COPD	☐ Hepatitis	☐ Miscarriage	☐ Stroke
☐ **Anxiety/Nervousness**	☐ **Decreased Sex Drive**	☐ Hernia	☐ Mumps	☐ Sudden Weight Loss
☐ Appendicitis	☐ **Depression**	☐ Herniated Disc	☐ Nausea	☐ Suicide Attempt
☐ Arm/Hand Pain	☐ Diabetes	☐ Herpes	☐ Neck Pain/Stiffness	☐ Tension
☐ Arthritis	☐ Diff. Falling/Staying Asleep	☐ High Cholesterol	☐ Night Pain	☐ Thyroid Problems
☐ Back Pain/Stiffness	☐ Dizziness	☐ **Irritability**	☐ **Osteo-porosis/penia**	☐ Tonsillitis
☐ Bleeding Disorders	☐ Emphysema	☐ Jaw Problems	☐ Parkinson's Disease	☐ Tuberculosis
☐ **Bloating**	☐ **Epilepsy**	☐ **Joint/Muscle Pain**	☐ Pinched Nerve	☐ Tumors/Growths
☐ **Blurred Vision**	☐ **Excessive Belly Fat**	☐ Kidney Disease	☐ Pins/Needles in Arms	☐ Typhoid Fever
☐ Bowel/Bladder Changes	☐ **Excessive Sweating**	☐ Leg/Knee Pain	☐ Pins/Needles in Legs	☐ Ulcers
☐ Breast Lump	☐ **Fatigue**	☐ Light Bothers Eyes	☐ Pneumonia	☐ **Unable to Lose Weight**
☐ Bronchitis	☐ Fainting	☐ Liver Disease	☐ Polio	☐ Venereal Disease
☐ Bulimia	☐ Fractures	☐ **Loss of Focus**	☐ Prostate Problems	☐ Whooping Cough
☐ Cancer	☐ Fever	☐ **Loss of Muscle Strength**	☐ Psychiatric Care	
☐ Cataracts	☐ Glaucoma	☐ Loss of Smell	☐ Rheumatic Fever	
			☐ Rheumatoid Arthritis	

Are you currently under medical care? ☐ Yes ☐ No If yes, explain: _____

List Medications/Supplements below:

	Name	Dosage	Frequency	Reason for medication
1.				
2.				
3.				

Please list any surgeries and/or hospitalizations you have had (type & date):

1._____ 4._____
2._____ 5._____
3._____ 6._____

Do you suffer from any Allergies? ☐ Yes ☐ No If yes, please list below:

Drug Allergies	Food Allergies	Seasonal Allergies

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ Never

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of: Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Subjective Questionnaire

What is your primary reason for seeking care? _____

_____

When did your symptoms begin? _____

How would you best describe your symptom(s)?

☐ Aching	☐ Sharp	☐ Stabbing	☐ Radiating
☐ Dull	☐ Burning	☐ Throbbing	☐ Numbness
☐ Difficulty Walking	☐ Constant	☐ Intermittent	☐ Hypersensitive
☐ Muscle Cramp/Spasm	☐ Decreased ROM	☐ Tingling	☐ Other _____

Please describe the frequency of your symptoms: _____

Is there anything that you can associate with the onset of your symptoms? (Example: injury, lifestyle, health condition, habits): _____

How would you describe the onset of your symptoms: ☐ Sudden ☐ Gradual

How would you describe the progression of your symptoms since the onset:

☐ Getting Worse	☐ Getting Better	☐ Off and On	☐ Increasing Frequency
☐ Same Frequency	☐ Decreasing Frequency	☐ _____	

What or when do your symptoms seem the worst?

☐ Sitting	☐ Sleeping	☐ Transition sit to stand	☐ Bending	☐ Walking
☐ Exercise	☐ End of Day	☐ Morning	☐ Lifting	☐ Up and Down Stairs

What seems to decrease your symptoms?

☐ Rest/Sleep	☐ Sitting	☐ Topical Meds/Oils	☐ Exercise/Stretching	☐ Medication
☐ Heat	☐ Change Position	☐ Ice	☐ Other _____	

What types of treatment have you tried in the past?

☐ Stretching ☐ Chiropractic ☐ Physical Therapy ☐ Medication ☐ Acupuncture ☐ Heat
☐ Massage ☐ Topical Meds/Oils ☐ Exercise ☐ Injections ☐ Ice ☐ _____

Please provide the names of the medication (both over-the-counter and/or prescription) that you have tried:

_____

Have you received any recent diagnostic testing related to your symptoms? ☐ Yes ☐ No If yes, any of the following?

☐ MRI ☐ X-Ray ☐ Vision Test (Headaches) ☐ NCV/EMG ☐ CT Scan ☐ _____

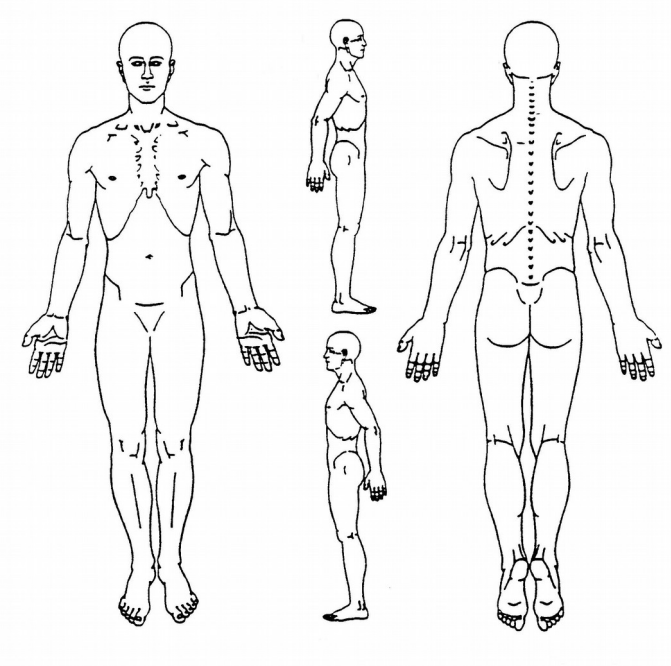
Do you have any numbness/tingling in the pelvic region or unintentional loss of bowel/ bladder control? ☐ Yes ☐ No

Rate your pain on a scale of 1-10 (1 being *little to no pain* and 10 being *extremely painful)*

1 2 3 4 5 6 7 8 9 10

Please mark the figure below with:

Muscle Spasm = S Burning = B Ache = A Numbness = N Pins & Needles = P



X-ray Questionnaire: For women only

Our consultation and examination may indicate x-rays are necessary. If so, please confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time. **☐ Yes, I am definitely pregnant.**
☐ No, I am definitely not pregnant at this time. **☐ I request that films not be taken because:**
Date of last Menstrual Period: _____ **_____**

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ Date:_____

Financial Information

Person responsible for this account (if not yourself):_____

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

Do you have health insurance? ☐ Yes ☐ No Carrier: _____

Assignment and Release (Insured Patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INTEGRATIVE HEALTH AND REHABILITATION, PC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Office Financial Policy

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or under-insured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or “prompt payment” option.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our “Hardship Policy” may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2019, our office will be unable to extend any type of discounts other than those listed above.

Health Insurance

If you are covered by health insurance, it is our policy to contact your insurance company to verify benefits are regarding the services provided in our office as well as filing insurance claims on your behalf. We require that your account be kept current and paid in full when services are rendered. Most insurances have a deductible and/or a co-payment. **If your health insurance carrier sends you a check for payment towards your account with this practice, you will be required to endorse that check and remit it to our office immediately.** Please keep in mind that **YOU** are responsible for payment of your entire bill. Therefore, in the event your insurance carrier (1) does not pay for a claim submitted within 45 days of the time of service, (2) denies coverage or (3) provides less coverage than anticipated, you will be personally responsible for payment of the account. We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, as well as CASH or CHECK.

General

If you are unable to pay your account in full at the time services are rendered, you should be aware that the following rules apply to your account:

A finance charge of two percent (2.00%) per month (24% a.p.r.) will be charged with a minimum of $5.00 on all accounts more than thirty (30) days old.

Sometimes it may be necessary to utilize a payment schedule with approval from this practice. If so, such a schedule must be strictly adhered to. In the event any payment is not made when due, the account will be turned over to collections. Should your account be turned over to collections, you will be required to pay all collection costs, attorney fees and court costs.

Patient Name: _____ Date: _____
(printed)

Patient Signature: _____ Witness: _____
Adult Patient, Parent/Guardian, or Spouse

Consent to Care

I hereby authorize the providers to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injections and diagnostic testing. I realize the goal of integrated healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, 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.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees to that he/she is responsible for all bills incurred at this office.

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

"National Supplier Clearinghouse Medicare DMEPOS Supplier Statement"

DMEPOS suppliers have the option to disclose the following statement in order to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by supplier legal business name or DBA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Patient Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the HIPPA Notice of Privacy Practices of Integrative Health and Rehabilitation.

Please check one of the following options and sign below:

I ☐ **DO** ☐ **DO NOT** wish to receive a copy of Privacy Notice. If you do not want a copy of the Privacy Notice at this time, a copy is available at any time and the Privacy Notice is posted in the office.

If you **DO** wish to receive a copy of Privacy Notice, we will provide a paper copy or email you one if you provide your email address:

_____ @_____.

Please initial below:

_____ I acknowledge that it is the policy of Integrative Health and Rehabilitation 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.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer/Office Manager about my concerns.

Missed Visit Policy

_____ I acknowledge that it is the policy of Integrative Health and Rehabilitation to charge the **FULL AMOUNT** owed for ***Physical Therapy, Massage Therapy*** and ***Nurse Practitioner*** visits if I fail to attend a scheduled appointment or fail to provide 12 hours notice to change my scheduled appointment.

Patient Name: _____ **Date:** _____
(printed)

Patient Signature: _____ **Witness:** _____
Adult Patient, Parent/Guardian, or Spouse