

Patient Information

Name: _____
Last First MI Prefer to be called

Phone: _____ Email address: _____
Cell Work

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

Date of Birth: _____ Sex: Male Female Age: _____ SS#(VA Only): _____ - _____ - _____

Marital Status: Single Married Divorced Widowed Separated

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____ Phone: _____

Whom may we thank for referring you? _____

How would you like your appointment reminders? Phone Email Text | Cell Provider: _____
(Verizon, AT&T, etc.)

May we send you our e-newsletter? Yes No

Financial Information

Person responsible for account (if not yourself): _____

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

Do you have health insurance? Yes No Carrier: _____

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:

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

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 |
|----------------|----------------|--------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

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? _____

How would you best describe your symptom(s)?

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Sharp | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Hypersensitive |
| <input type="checkbox"/> Muscle Cramp/Spasm | <input type="checkbox"/> Decreased ROM | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other _____ |

Please describe the frequency of your symptoms: _____

Approximately how long ago did you first notice the 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:

- | | | | |
|---|---|-------------------------------------|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Getting Better | <input type="checkbox"/> Off and on | <input type="checkbox"/> Increasing Frequency |
| <input type="checkbox"/> Same Frequency | <input type="checkbox"/> Decreasing Frequency | <input type="checkbox"/> _____ | |

What or when do your symptoms seem the worst?

- | | | | | |
|-----------------------------------|-------------------------------------|--|----------------------------------|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Transition sit to stand | <input type="checkbox"/> Bending | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> End of Day | <input type="checkbox"/> Morning | <input type="checkbox"/> Lifting | <input type="checkbox"/> Up and Down Stairs |

What seems to decrease your symptoms?

- | | | | | |
|-------------------------------------|--|--|--|-------------------------------------|
| <input type="checkbox"/> Rest/Sleep | <input type="checkbox"/> Sitting | <input type="checkbox"/> Topical Meds/Oils | <input type="checkbox"/> Exercise/Stretching | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Change Position | <input type="checkbox"/> Ice | <input type="checkbox"/> 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 _____

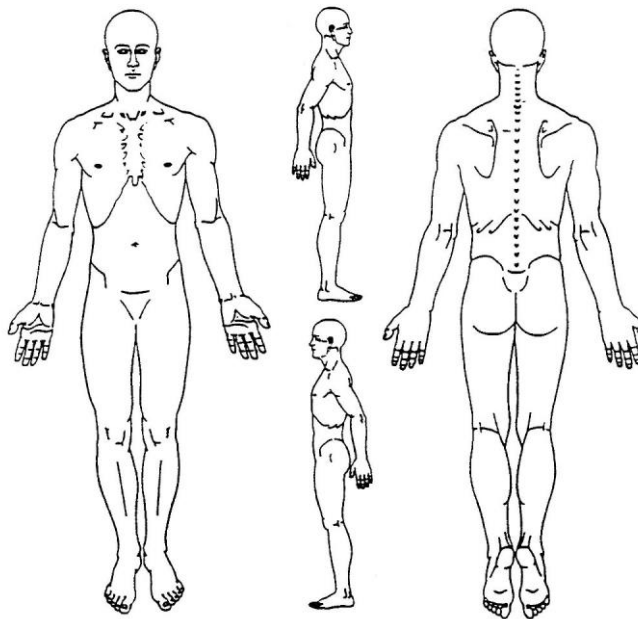
Do you have any numbness/tingling in the pelvic region or unintentional loss of bowel/ bladder control? Yes No

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:** _____

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, to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

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.

Office Financial Policy

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 DMCO that you may join. Patients who are uninsured, or under-insured (limited benefits), will be entitled to network discounts similar to our insured patients. There is NO FEE to join, and this plan covers you and your dependents. See details at www.patientoptions.org.
- 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.

Patient Responsibility - It is your responsibility to verify that Integrative Health and Rehabilitation accepts your insurance. Please bring your insurance card to all your visits and be prepared to any previous outstanding balance on your account.

Co-Payments -Commercial plans with established co-pays are due at the time of service.

High Deductible Plans - Full payment for services will be collected at time of your visit. We will submit your claim to your insurance company and balance bill once the claim is processed. Any excess payment will be promptly reimbursed to you.

Missed Visit Policy - **12 hours’ notice** is required to change a scheduled appointment. A **\$50 FEE** will be charged for patients that miss a Massage, Physical Therapy, or Nurse Practitioner appointment more than one time in a 12-month period. The fee will be charged for the 2nd and 3rd missed appointment and the patient will be dismissed from the practice on the 4th occurrence.

Balances - 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 Options Enrollment Agreement - As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is **NO FEE** for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions are between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be re-enrolled for successive one-year (12 month) periods unless request in writing.

There are no fees, dues, charges, or other consideration required for participation.

Disclosures –

- The Program provides discounts to you from contracted healthcare providers for services rendered.
- The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options.
- This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third-party insurance company is responsible for charges.
- Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement.
- The name and address of the Discount Managed Care Organization is **Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633**

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

**Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

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

Consent to Care

I hereby authorize the providers to treat my case as they deem appropriate using 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 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 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.

Patient Name

Patient (or guardian) Signature

Date