Confidential Patient Information

Ultimate Health and Rehab
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Springfield, MO 65804

Phone: (417)438-8035

www.ultimatehealthrehab.com

Date: ____/____/_____

Patient's Full Name _____

Mailing Address: _____City:_____State:_____Zip:_____

Home Phone: (____)_____ Cell Phone: (____)_____ Day Time Phone (____)_____
Email:_____

Date of Birth: ____ /____ /_____ ☐ Male ☐ Female Spouse's Name: _____

☐Married ☐Single ☐ Widowed ☐ Separated ☐Divorced Number of Children/ Ages: _____

How did you hear about us? (Friend, Relative, Physician, Google, Social Media, etc.) _____

Status: ☐Employed ☐Full Time Student ☐ Part Time Student ☐Retired ☐Unemployed

Occupation: _____ Employer: _____

What type of care are you interested in: ☐ Pain relief only ☐Healing of current condition ☐Optimizing your health ☐All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

_____

_____

Your Education level: ☐High School ☐ Some College ☐ College Graduate ☐Post Graduate ☐Other: _____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐No **Is Today's Visit Due to An Auto Accident**: ☐Yes ☐No

Date of Injury: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjustor for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** to settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Ultimate Health and Rehab are paid in full.

Patient Signature_____ Date_____ / _____ / _____

Confidential Patient Information

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. *THANK YOU*.

Current Health History:

Primary Complaint_____

Secondary or related complaint(s) if any: _____

Date of Onset / When did your symptoms begin? _____ Have you had this problem before? ☐Yes ☐ No

Was the Onset: ☐ Gradual ☐ Sudden Since its' onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain: _____

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If Yes, explain; _____ Results:_____

What medications are you currently taking? _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

In general, would you say your health is (check one): ☐Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐Yes ☐ No If Yes, explain_____

Was treatment provided: ☐ Yes ☐ No If yes, By whom: _____Outcome:_____

2. Have you **ever** had a **stroke** or issue with **blood clotting**? ☐Yes ☐No If yes, When: _____

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐No If Yes, explain:_____

_____

4. Have you **ever** had any **major illnesses, injuries, broken bones**, **hospitalizations, accidents, or surgeries**? ☐ Yes ☐No
If yes, explain: _____

SOCIAL HISTORY:

Recreational Activities (Hobbies): _____

Yes	No	
☐	☐	Do you exercise? _____(#)times per week? What type of exercise?_____
☐	☐	Do you smoke? _____(#)packs per day
☐	☐	If you have quit smoking, when did you quit? _____
☐	☐	Do you use other forms of tobacco? What/How much per day? _____
☐	☐	Do you consume alcohol? If yes, how many drinks per week? _____
☐	☐	Do you eat a balanced diet? If no, explain: _____
☐	☐	Do you get adequate sleep? If no, explain: _____
☐	☐	Is work stressful to you? If yes, explain: _____

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Current Health History Continued:

Who is your primary care physician? _____ phone # _____
What makes your current condition(s) better? _____

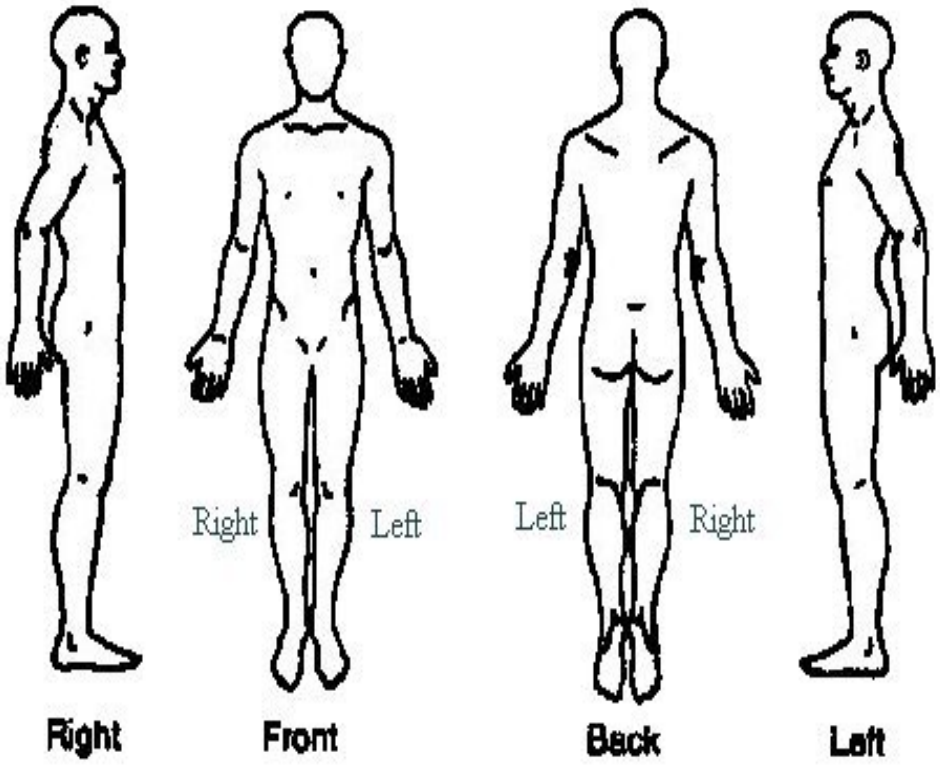
What makes your current condition(s) worse? _____

Does the pain / altered sensation(s) radiate or travel from one part of your body to another? _____
If so, where? _____
Does your condition(s) wake you up at night? _____
Have you noticed any difference in when you feel the problem(s) (such as time of day, specific activities, etc) ?_____

PAIN CHART

Please Mark the Areas of Pain using these Codes

+++ Burning xxx Dull Ache /// Numbness/Tingling ===Throbbing OOO Sharp/Stabbing



Example: +++ ⟶ to the area of the body.

SEVERITY OF PAIN

1. **Complaint**_____

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable**

2. **Complaint**_____

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable**

3. **Complaint**_____

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable**

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although stroke happens with some frequency in our world, strokes from chiropractic adjustment are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting struck by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescriptions or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____Signature of Patient Date _____

_____Signature of Parent or Guardian (if a minor) Date _____

_____Signature of Witness Date _____

Financial/Privacy Policy Disclaimer

Insurance Verification

- Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing

Deductible Payments

- It is our policy to collect at the time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill.
- In the event a bill is disputed, you must notify us within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- All balances remaining unpaid after 30 days may be turned over to a collection agency.

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and our other patients, **please give us 24-hour notice**. If it is a continual problem, there will be a **$20.00** charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct questions to our billing administrator, currently Dr. Reed.

HIPAA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate UHR to the full extent permissible under the Employment Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Ultimate Health and Rehab. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

- I do hereby authorize Ultimate Health and Rehab to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Ultimate Health and Rehab.

_____ _____

patient signature **date**