Advanced Rehab & Medical/ Back Pain Relief Clinic/ 45 Urgent Care

New Patient Information

Name_____ ☐ Female ☐ Male Date _____

What you prefer to be called_____Age_____Date of birth _____

Preferred Language ☐ English ☐ Other_____Race: ☐ White ☐ African American ☐ Other _____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone _____

Email Address_____SS#_____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relation_____Phone_____

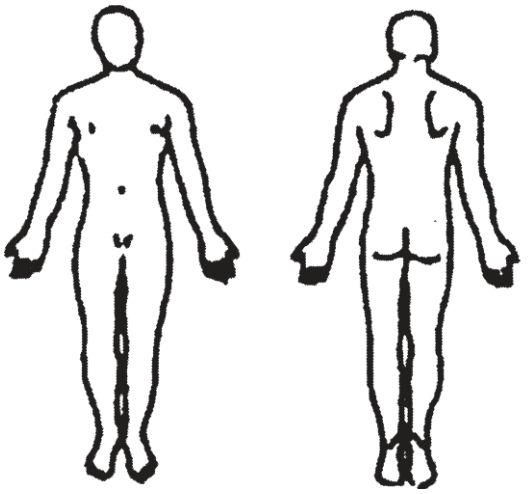
How did you hear about our office? _____

When did your condition begin?_____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition_____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

(3)_____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician/ PCP_____

May we forward our findings to your doctor? ☐ Yes ☐ No

Allergies (Medicine, Food, Environment)

_____

_____

Previous Surgeries _____

Other serious illnesses_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Heart Disease	❑	❑	❑	polio	❑	❑	❑	hepatitis
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	cancer
❑	❑	❑	arthritis	❑	❑	❑	tuberculosis	❑	❑	❑	kidney disorder
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	rheumatic fever
❑	❑	❑	diabetes	❑	❑	❑	rheumatism	❑	❑	❑	HIV/ARC
❑	❑	❑	scarlet fever	❑	❑	❑	multiple sclerosis				
❑	❑	❑	Stroke	❑	❑	❑	high blood pressure				
❑	❑	❑	muscular dystrophy	Other serious illness: _____							

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Social History

Do you smoke? Yes ____ No ____ If yes, how much? _____

Do you drink alcohol? Yes ____ No ____ If yes, how often? _____

Do you or have you taken illicit drugs? Yes ____ No ____ If yes, describe _____

Health Insuarnce:

Policyholder Name_____Date of Birth _____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care (Shannon Bone, DC; Mark Fowler, MD; Meagan vonHoltz, DC; Adam Copeskey, DC; Elena Jamscek, PA-C; Lisa Medlin, DNP; Chad Zawacki, PA-C) and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature_____Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being_____, age_____, do hereby authorize, request & direct Premier Rehab, Ltd., it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____ _____

ADVANCED REHAB & MEDICAL

PATIENT NAME:_____ TODAY'S DATE:_____

DATE OF BIRTH:_____

PLEASE CIRCLE YES IF YOU HAVE ANY OF THESE CONDITIONS CURRENTLY
IF YOU HAVE NOT HAD A SPECIFIC CONDITION PLEASE CIRCLE NO

GASTROINTESTINAL			***HEENT***			***NEUROLOGICAL***		
Nausea	NO	YES	Sore Throat	NO	YES	SEIZURES	NO	YES
Vomiting	NO	YES	Hoarseness	NO	YES	HEADACHES	NO	YES
Heartburn	NO	YES	Ear Pain	NO	YES	Dizziness	NO	YES
Painful Swallowing	NO	YES	***CARDIOVASCULAR***			***DERMATOLOGY***		
Vomiting Blood	NO	YES	Abnormal Heart Beat	NO	YES	Rash	NO	YES
Black Stool	NO	YES	Chest Pain	NO	YES	Itching	NO	YES
Red Blood in Stool	NO	YES	Palpitations	NO	YES	Wounds	NO	YES
Abdominal Pain	NO	YES	Swelling Feet	NO	YES	***Musculoskeletal***		
Constipation	NO	YES	***RESPIRATORY***			Joint Pain	NO	YES
Diarrhea	NO	YES	Cough	NO	YES	Arthritis	NO	YES
Loss of Appetite	NO	YES	Shortness of Breath	NO	YES	Weakness	NO	YES
Bloating	NO	YES	Wheezing	NO	YES	***Psychiatric***		
			Phlegm	NO	YES	Depression	NO	YES
						Anxiety	NO	YES
						Bipolar	NO	YES
CONSTITUTIONAL			***GENITOURINARY***					
Recent Weight Gain	NO	YES	Frequent Urination	NO	YES			
# of Pounds _____			Kidney Failure	NO	YES			
Recent Weight Loss	NO	YES	OR Dialysis					
# of Pounds _____			Painful Urination	NO	YES			
Fever	NO	YES	Date of Last Menstrual					
Fatigue	NO	YES	Period _____					
Chills	NO	YES						

() By checking this box, I agree that only the problems I am currently having and seeking attention for are marked YES!

PATIENT SIGNATURE: _____

Pt. Name: _____ Date of Birth: _____

Please list all medications, vitamins and nutritional supplements that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Reason for Taking

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health. I certify that I, or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Rehab and Medical/Back Pain Relief Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all submissions. The above-named doctor may use my health care information to above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Guardian Date

Advanced Rehab and Medical/ Back Pain Relief Clinic
45 Urgent Care

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Advanced Rehab and Medical/ Back Pain Relief Clinic/ 45 Urgent Care to obtain a copy of my patient records or x-rays containing protected health information. This authorization is given pursuant to Tennessee Statutes and HIPAA regulations. I authorize that any third party to whom records are disclosed should not be further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____
Printed Name of Patient Patient's Date of Birth

_____ _____
Signature of Patient or Legal Guardian Patient Phone Number

_____
Date Signed

Specific description of information to be disclosed:

____ Xrays
____ MRI of _____
____ NCV/EMG of _____
____ Lab/ Lab Report
____ Office Notes
____ Other _____