Patient Information

Appointment Date: _____

Name: _____
Last First MI

Email Address: _____

Mailing Address: _____
City State Zip

Phone #: (H) _____ (Cell) _____ (W) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Gender: ❑ M ❑ F ❑ ____ Sex at Birth: ❑ M ❑ F SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other:_____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Non-Hispanic/Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone #:_____

How did you hear about our practice? _____

Emergency Contact:_____ Relation: _____

Phone #: (H) _____ (Cell) _____ (W) _____

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? _____

Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Policy Holder Name: _____ DOB: _____

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

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

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, 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 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 the signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE:** _____

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, 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. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

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, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Signature: X_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Healthcare PLLC.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office 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.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

Name: _____ DOB: _____ Date: _____

Health History

Vitals: Ht: _____ Wt: _____ BP: _____ P: _____ SP02: _____

Medical History:

- ❑ Arthritis
- ❑ Herniated Disc
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Pinched nerve
- ❑ Ulcers
- ❑ Bleeding Disorders
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Pacemaker
- ❑ Stroke
- ❑ Cancer
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Thyroid Issues

Please Describe (if applicable): _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care doctor? _____

Please all medications: (*Be sure to include dosage and frequency*) _____

Supplements (*vitamins/herbs/minerals*): _____

Allergies: _____

Surgeries and/or hospitalizations (*type & date*): _____

Approximate Date of last Flu vaccine: _____

WOMEN ONLY Date of LMP: _____ ***Any possibility of pregnancy***? ❑ Yes ❑ No

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings):

- ❑ Heart Disease _____
- ❑ Diabetes _____
- ❑ Other _____
- ❑ Cancer _____
- ❑ Arthritis _____

Intake of following: Cigarettes _____ packs/day Alcohol_____ drinks/week Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly_____ ❑Walks ❑Runs ❑Swims_____

Occupation: _____ Does work mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Reviewed with patient by: _____

Notes: _____

Review of Systems

Y N **Neurological**
___ ___ Migraines
___ ___ Headaches
___ ___ Slurring of Speech
___ ___ Ringing in Ear(s)
___ ___ Pins & Needles- Arms
___ ___ Pins & Needles- Legs
___ ___ Cold Hands/Feet
___ ___ Dizziness

Ear/Nose/Throat
___ ___ Altered taste/smell
___ ___ Night Blindness
___ ___ Sore Throat
___ ___ Gingivitis
___ ___ Nose Bleeds
___ ___ Loss of Smell
___ ___ Loss of Taste
___ ___ Blurred Vision

Cardiovascular
___ ___ Chest Pain
___ ___ Heart Palpitations
___ ___ Swelling in hands/feet
___ ___ Anemia

Respiratory
___ ___ Recurrent Respiratory Infections
___ ___ Allergies
___ ___ Asthma
___ ___ Chest Congestion
___ ___ Wheezing
___ ___ Frequent Sneezing
___ ___ Shortness of Breath

Y N **GI**
___ ___ Stomach Pains/Cramping
___ ___ Constipation
___ ___ Reflux /Heartburn
___ ___ Bloating
___ ___ Gas
___ ___ Nausea/Vomiting

Musculoskeletal
___ ___ Joint Pain
___ ___ Arthritis
___ ___ Chronic Pain
___ ___ Muscle Aches
___ ___ Jaw Problems
___ ___ Tension

Skin/Hair/Nails
___ ___ Eczema
___ ___ Dermatitis
___ ___ Excessive Sweating
___ ___ Rashes
___ ___ Brittle Nails
___ ___ Hair Loss
___ ___ Easy Bruising
___ ___ Increased Bleeding
___ ___ Numbness/Tingling

Emotional/Mental
___ ___ Depression
___ ___ Anxiety
___ ___ Nervousness
___ ___ Mood Swings
___ ___ Irritability
___ ___ Memory Loss
___ ___ Confusion

Y N **Energy**
___ ___ Fatigue
___ ___ Hyperactivity
___ ___ Restlessness
___ ___ Insomnia
___ ___ Decreased Libido
___ ___ Stress

Weight
___ ___ Decreased Appetite
___ ___ Weight Gain
___ ___ Inability to Lose Weight
___ ___ Food Cravings
___ ___ Binge Eating
___ ___ Water Retention
___ ___ Sudden Weight Loss

Genitourinary
___ ___ Uterine Fibroids
___ ___ Ovarian Cysts
___ ___ Cancer (breast, ovarian, prostate, uterine)
___ ___ Prostate Problems

Other Symptoms Not Listed:_____
_____
_____
_____
_____
_____

FINANCIAL POLICIES AGREEMENT

_____ **PAYMENT:** Payment for all services are due in full at the time services are rendered. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.

_____ **PATIENT COOPERATION and NO GUARANTEE OF RESULTS**: It is illegal and highly unethical for any doctor to guarantee results for any health care condition. However, we can speak of our experience and the success rate our office has had. We assure you that we as an office will do everything in our power to ensure you have a favorable outcome. In order to get the best results, please follow the visit frequency laid out in your care plan along with all healthcare provider recommendations. Patient recognizes this agreement is not a guarantee of results and deals solely with the services to be rendered and the fees to be paid for the care as provided. The patient's payment obligation is not contingent upon the outcome of care.

_____ **SUBSEQUENT INJURIES:** The care the patient is to receive under this care plan has been determined based upon the patient's present condition. If a new injury or condition arises during the course of treatment provided for in this care plan, the current care will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. Notify the office immediately if you have any type of accident whether work, auto, or home related.

_____ **POSSIBLE ADDITIONAL CHARGES:** Additional items needed to support the patient's care such as orthopedic supports, orthotics, cervical pillow, additional diagnostic testing, exercise materials, laboratory tests, x-rays and/or analysis, nutritional support and other similar things will be separately charged for and payment for said care shall be due at the time received by the patient. Only items clearly stated in the patient's Doctor Ordered Treatment Plan will be covered under the agreement.

_____ **NON-REFUNDABLE ITEMS**: All Durable Medical Equipment and nutritional supplements are non-returnable and non-refundable once they leave the office whether they are opened or not.

_____ **MISSED APPOINTMENT FEE**: There is a $25.00 charge for no call/no show massages. You will be considered a "no show" if you do not call the office and reschedule at least 30 minutes prior to closing the night before your scheduled massage. The missed appointment charge will be auto-debited from your credit card/bank account on file. If you have purchased a group-on massage and are a no call/no show as described above you will forfeit the massage.

Please Print, Sign & Date below that you read & understood all of our financial policies & agree to abide by all the terms above.

Patient Name: _____ **Signature:** _____ **Date:**_____