Select Spine & Sports Medicine, PPLC

Name: _____ DOB:_____Gender: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Email: _____

Emergency Contact: _____

Who can we thank for referring you? _____

My Financial Responsibility:

I understand that I am financially responsible for charges incurred at Select Spine & Sports Medicine, whether I am using a health insurance plan or other third party, ultimately my healthcare choices are my financial responsibility. I authorize Select Spine & Sports Medicine to use my signature on all health insurance submissions. Select Spine & Sports Medicine may use my health information and may disclose such information to above name company for purposes of obtaining payment for services rendered. I certify that I and/or my dependent assign benefit coverage to Select Spine & Sports Medicine. Should I receive any payment from my insurance company for services rendered at Select Spine & Sports Medicine, I will immediately assign the check in full to Select Spine & Sports Medicine. For any reason, should charges be deemed not covered by my health plan, I understand that I am fully responsible for all charges incurred.

Signature: _____ Date:_____

I am seeking: ☐Medical Care ☐IV Infusion Therapy ☐Chiropractic Care ☐Massage
(IV only can skip to page 2)

Briefly describe your chief complaint. (Ex: Back pain, tingling in leg, headaches, etc)
_____

How did this problem begin? _____ How long ago? _____

How often do you feel it? ☐Intermittent (1-25% of the day) ☐Occasional (26-50% of the day)
☐Frequent (51-75% of the day) ☐Constant (76-100% of the day)

Rate your pain: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

How does it feel? (Ex: Dull, achy, stiff, sharp, stabbing, numb, tingling, burning, throbbing)
_____

What makes it feel better? _____ What makes it feel worse? _____

How has it changed over time? ☐Better ☐Same ☐Worse

Have you had treatment for this in the past? ☐No ☐ Yes If so, what type?_____

Have you had recent imaging? (Ex: X-ray, MRI, CT) ☐No ☐ Yes

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CARDIOVASCULAR AND RESPIRATORY

☐ High Blood Pressure ☐ Asthma ☐ Thrombosis or DVT ☐ Cardiac Surgery or Stents
☐ Heart Murmur ☐ COPD ☐ Aneurysm ☐ Congestive Heart Failure
☐ Valve Disorder ☐ Sleep Apnea ☐ Heart Attack ☐ Pulmonary Hypertension
☐ Abnormal Rhythm ☐ Shortness of Breath ☐ Chest Pain ☐ Lung Cancer
☐ Peripheral Arterial Disease ☐ Other Cardiopulmonary Disorder _____

GASTROINTESTINAL AND URINARY

☐ Acid Reflux ☐ Liver Disease ☐ Bladder Disease ☐ Hepatitis A, B, C
☐ Kidney Disease ☐ Other _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

☐ Hyper/Hypo Thyroid ☐ Rheumatoid Arthritis ☐ Diabetes Type I or Type II
☐ DKA ☐ Lupus ☐ Other _____

NEUROLOGICAL

☐ Stroke/TIA ☐ Multiple Sclerosis ☐ Parkinson's ☐ Alzheimer's ☐ Seizures

HEMATOLOGY

☐ Anemia ☐ MTHFR ☐ G6PD Deficiency

MUSCULOSKELETAL

☐ Back Pain ☐ Degenerative Joint Disease ☐ Carpal Tunnel Syndrome
☐ Degenerative Disk Disease ☐ Fibromyalgia ☐ Other_____

PSYCHOLOGICAL

☐ Depression ☐ Anxiety or Panic Attacks ☐ Suicidal Ideations

CANCER

☐ Cancer - Location: _____ ☐ Chemotherapy ☐ Radiation

WOMEN (non-menopausal)

Last Menstrual Period _____ Any chance that you are pregnant? ☐ Yes ☐ No
Breast Feeding? ☐ Yes ☐ No

PAIN

☐ CRPS ☐ Fibromyalgia

Height: _____ Weight: _____
List all food and drug allergies:_____
List all current medications and supplements:_____
List all surgeries: _____
List year of any previous auto collisions:_____
Alcohol or drug abuse? ☐ No ☐ Yes If so, please explain:_____
Any other conditions or injuries you want us to know about?_____

I attest that the information I have provided is true and accurate to the best of my knowledge.

Print Name:_____

Signature:_____Date_____

Select Spine & Sports Medicine, PPLC

Office Financial Policy

- Please keep in mind, the time you are scheduled is valuable, not only our staff but to someone else who could have scheduled during that time. Therefore, it is important that you notify us in advance of any changes to your scheduled appointment, so we have the opportunity to fill the appointment time slot with someone who needs to get in sooner.

  For No show or late cancel (24 hrs) the following charges will apply:
  - **New Patient: $80**
  - **Massage:**
    - **30-minute massage: $30**
    - **60-minute massage: $60**
  - **IV Infusion Therapy: $60**

- Payment must be made at the time of service.

- If using health insurance, your payment will be determined by what your benefits are showing on your health insurance portal. Unfortunately, we cannot go by your word. After your claims have been submitted, processed and upon receipt of explanation of benefits (EOB), if there is a difference in the amount charged and the amount owed, we will make that correction to your account. No refunds will be made until a final EOB is received.

- Health insurance does not ever cover the following: IV Infusions, Vitamin Injection and Spinal Decompression Therapy.

- There are no refunds for products or services rendered.

- There will be a $25 charge for returned checks due to insufficient funds and no further checks will be accepted until the first checks clears.

- We do not file out of network claims. If we are not in-network with your health insurance company or the service provided is not a covered service, we welcome you to submit those claims on your behalf.

I have read, understand, and agree to all of the above statements.

Print Name:_____

Signature:_____Date_____

Select Spine & Sports Medicine, PPLC

Informed Consent

A patient, in coming to Select Spine & Sports Medicine, has options in their healthcare plan within this office. This form authorizes our healthcare team to work using a collaborative approach. I give permission to the healthcare providers at Select Spine & Sports Medicine to perform a history, physical examination and render a diagnosis. Upon explanation of such diagnosis, my treatment plan and treatment options will be described, and verbal consent will be requested prior to any and all treatment performed.

I understand and agree to the following:

- I am voluntarily seeking care at Select Spine & Sports Medicine.
- I have filled out the health history form in its entirety and understand an omission could cause undo harm or side effects.
- Benefits of Medical care, IV and injection therapies provided at Select Spine & Sports Medicine include: decreased pain, decreased inflammation, weight loss, better quality of sleep, improved quality of life.
    - Medical care involves prescribing or administering prescription medications.
    - IV Infusion involves inserting a needle into a vein
    - IM or SubQ injections involve having a solution injected into my muscle or fat.
    - Common risks involved with IV and injection therapies include, but are not limited to, irritation, pain, discomfort, bruising, and bleeding at the site of the IV insertion or injection.
    - Less common risks involved with IV and injection therapies include, but are not limited to, infection at the site of the IV insertion or injection, injury to the tissue, phlebitis, low blood pressure, fainting, fluid volume overload, medication interactions, and drops in blood sugar levels.
    - Rare side risks involved with IV and injection therapies include, but are not limited to, sepsis, severe allergic reactions, severe medication/supplement interactions, anaphylaxis, blood clots, shock, cardiac arrest, and death.
    - Potential common B12 side effects include, but are not limited to: mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.
    - Potential common lipotropic injection side effects include, but are not limited to: stomach upset, diarrhea, urinary frequency/urgency/hesitancy, fatigue, elevated heart rate, and restlessness.
- Benefits of Chiropractic care include: decreased pain, increase range of motion, decreased inflammation, increased strength, increased performance, better quality of sleep, improved quality of life.
    - Chiropractic manipulation involves gapping the facet joints of the spine or other extremity joints.
    - Common risks involved with Chiropractic is muscular or joint soreness for 24-48 hrs.
    - Less common risks involved with Chiropractic include: dizziness, muscle strain, rib fracture.
- I acknowledge that there are no guarantees regarding the results of treatment and its effect on my condition.
- I understand the risks and benefits of the procedures outlined above and have had all my questions answered to my full satisfaction.
- I understand that unforeseeable complications can arise when an IV is placed and medications/fluids/minerals/vitamins are infused into the body.
- I understand that I have the right refuse any treatments or treatment recommendations at any time.
- I give my consent for the use of emergency intervention if required during treatment.
- I certify that I am of sound mind and body to make medical decisions and to consent for treatment.
- I release Select Spine & Sports Medicine, PLLC and all the medical staff from all liabilities for any complications or damages associated with IV infusion and injection therapy.

I have read this consent and fully understand the information within it and I voluntarily authorize and consent to the treatment options, including but not limited to IV infusion therapy, provided to me at Select Spine & Sports Medicine, PLLC.

Print Name:_____

Signature:_____Date_____

Select Spine & Sports Medicine, PPLC

Privacy Policy

OUR LEGAL RESPONSIBILITIES
We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information. We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information. You may request a copy of our notice any time. You may contact us at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations, etc. But please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you by telephone, email, or text to remind you of your appointments. Sometimes we must share your protected health information to third party "business associates" such as a billing service. If so, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Print Name:_____

Signature:_____Date_____