APEX HEALTH
SPINE & SPORT

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# CONFIDENTIAL PATIENT INFORMATION

Patients Name _____ Date of Birth _____

Address _____ Chief Complaint _____

City _____ State_____ Zip _____ Cell # _____

SS# _____ Email _____

Address of Insured (if different than above) _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) _____Yes_____ No

Ins. Company _____ Ins. Phone # _____

ID# _____ Group# _____

Name of Policy Holder _____ Policy Holder DOB _____

Policy Holders Employer _____

Family Physician_____ (Note: May we send your health information to this provider Y I N)

Person to contact in case of emergency (Name and Phone) _____

Have you ever had chiropractic care or physical therapy? Y N If so, Who? _____

Have you had any X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What surgeries/fractures have you had (and when)?_____

Serious Illness _____ When?_____

Infectious Diseases_____ When?_____

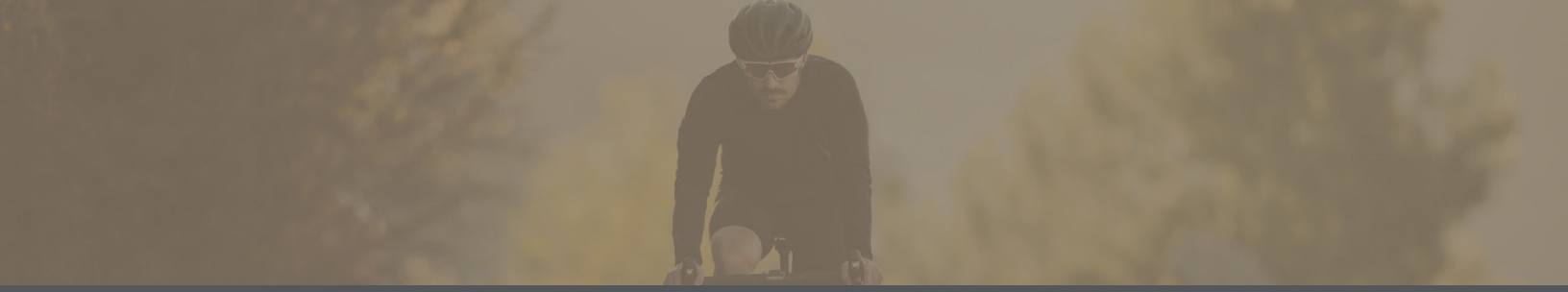
Do you have a pace maker? Y / N Have you ever had any joint replacements (Hip, Knee, Shoulder, etc.) Y / N

What medications or drugs are you taking? (check those that apply):

Pain Killers ○ Insulin ○ Cholesterol Meds ○ Blood Pressure Meds ○ Muscle Relaxers ○ Birth Control ○ Antidepressants ○

Other: _____

What is your goal in our office?_____



# LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL & PLAN DOCUMENTS

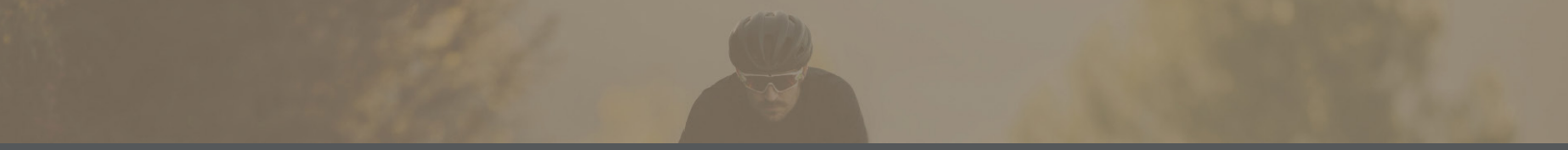
In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Apex Health Spine & Sport** all medical benefits and/or insurance reimbursement, if any, otherwise payab¬le to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

Date



# TERMS OF ACCEPTANCE

Patient Name _____ Date _____

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

**Please read the below and if you have any questions please feel free to ask one of our staff members.**

## INFORMED CONSENT

A patient, in coming to the chiropractic doctor or physical therapist, gives the doctor or physical therapist permission and authority to care for the patient in accordance with the performed tests, diagnosis, and analysis. The chiropractic or physical therapy treatments and clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor or physical therapist, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician and/or physical therapist. The chiropractic doctor and physical therapist provide a specialized, non-duplicating health care service. Your doctor of chiropractic and/or physical therapist is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Apex Health Spine & Sport, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment or physical therapy, will be explained to me upon my request. I give consent to request my RX history online. I give consent to keep my encrypted credit card information on file for any future authorized payments.

## MISSED APPOINTMENTS

While we are sensitive to the fact than an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. Therefore a scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE or a $20.00 fee will be charged for that appointment. Failure to show up for an appointment (NO SHOW) will result in the $20.00 fee. The patient is responsible for these fees, not the insurance or third party payor. Repeated failure to comply with this policy will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an appointment on the day you wish to have the appointment to see if there is an opening. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

## WOMEN ONLY

To the best of my knowledge **I AM NOT** pregnant and **I GIVE PERMISSION** to x-ray for diagnostic interpretation. **I agree to inform Apex Health Spine & Sport if this changes at any point in the future.**

## CONSENT TO EVALUATE & TREAT A MINOR

I verify that I am the parent or legal guardian. I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

## ACKNOWLEDGEMENT

**I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.**

Signature_____ Date _____