APEXHEALTH
SPINE & SPORT
3014 Bashor Rd., Goshen IN 46526 P: (574) 533-2531 F: (574) 533-7788

Date: ____________________

# Confidential Patient Information

Patients Name: ________________________________ Date of Birth: ___________________________________

Address: _____________________________________ Home Phone: ___________________________________

City: _______________ State: ____ Zip:__________ Cell Phone: _____________________________________

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

Family Physician: _______________________________ (Note: May we send your health information to this provider? (Y / N)

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

Have you had any X-rays / MRI's / CT's taken in the last 2 years? Y N If so, Where? ________________________________

______________________________________________________________________________________________

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND 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 payable to me for services rendered from such provider and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider 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 provider and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such provider and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the provider and clinic 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 provider and clinic to the full extent permissible under the law and under 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 provider 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 provider and clinic in any attempts by such provider 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 provider and clinic against such insurers and/or employee health care plan in my name but at such provider 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

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Patient Name: ______________________________________________ Date: ________________

# PATIENT PEDIATRIC HISTORY FORM

## PAST MEDICAL HISTORY

Please list previous surgeries and dates. ____________________________________________________________
______________________________________________________________________________________

Please list previous fractures. ________________________________________________________________

Please list all other health conditions (cancer, diabetes, etc.) for which you have been diagnosed.
______________________________________________________________________________________
______________________________________________________________________________________

Do you have any allergies? ____________________________________________________________________

## REVIEW OF SYSTEMS: Are you *currently* experiencing any of the following symptoms/conditions? (Please circle)

Y N Fever/Chills
Y N Headaches
Y N Dizziness/Lightheaded
Y N Double Vision
Y N Blurry Vision (New Onset)
Y N Persistent Cough
Y N Chest Pain
Y N Shortness of Breath
Y N Abdominal Pain
Y N Nausea
Y N Joint Swelling
Y N Skin Discoloring / Rash
Y N Weakness/Fatigue
Y N Bowel/Bladder Changes

## HOW CAN WE HELP YOU TODAY?

**PRIMARY COMPLAINT:** ____________________________________________ Date symptoms began: _____________

How did it begin? _______________________________________________________________________________

Please list any previous treatments for this condition. _____________________________________________________

What makes it worse? ____________________________________ What makes it better? ________________________

**SECONDARY COMPLAINT:** __________________________________________ Date symptoms began: _____________

How did it begin? _______________________________________________________________________________

Please list any previous treatments for this condition. _____________________________________________________

What makes it worse? ____________________________________ What make it better? ________________________

# TERM OF ACCEPTANCE

Patient Name: ________________________________________________________ Date: _________________

The goal of Apex Health Spine & Sport 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 paragraphs below. If you have any questions, please feel free to ask one of our staff members.

## INFORMED CONSENT

A patient, in coming to Apex Health Spine & Sport, gives the health care provider permission and authority to care for the patient in accordance with the performed tests, diagnosis, and analysis. The 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 provider, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known to the provider any previously diagnosed pathological defects, illnesses or deformities which would otherwise not come to the attention of the provider. The healthcare professional provides a specialized, non-duplicating healthcare service. The provider is available to work with other types of providers in your healthcare regimen.

I understand that if I am accepted as a patient by a provider at Apex Health Spine & Sport, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any potential risk involved will be explained to me upon my request.

I give consent to request my RX (medical prescription) 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 that any emergency may occur in a rare instance, last minute patient cancellations or patient no-shows decrease our ability to accommodate the scheduling needs of other patients. Therefore, a scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE,** or a **$25.00 FEE** will be charged for that appointment. Failure to show up for an appointment **(NO SHOW)** will result in a **$25.00 FEE**. The patient is responsible for these fees, not the insurance company or third-party payer. Repeated failure to comply with this policy may 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 an 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 the highest 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 AND 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 care.

## ACKNOWLEDGEMENT

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

Patient Signature: ________________________________________________________ Date: _____________