

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

Patient Name: _____

Date: _____

PATIENT HISTORY FORM

PAST MEDICAL HISTORY

Please list previous surgeries and dates. _____

Please list previous fractures. _____

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

Do you smoke? No Previous Smoker, date of cessation: _____ Current Smoker: _____ pks per day

Do you exercise regularly? No Yes. How many times per week and what type? _____

Do you have either of these allergies? Dairy Shellfish Neither

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

Y N Fever/Chills	Y N Shortness of Breath	Y N Depression
Y N Headaches	Y N Chest Pain	Y N Skin Discoloring/Rash
Y N Dizziness/Lightheaded	Y N Abdominal Pain	Y N Numbness/Tingling
Y N Blurry Vision (New Onset)	Y N Nausea	Y N Weakness/Fatigue
Y N Double Vision	Y N Arthritis	Y N Blood Clots/Blood Thinner
Y N Persistent Cough	Y N Joint swelling	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: _____