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

Date: _____

Confidential Pediatric Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

City: _____ State: ____ Zip:_____ I give permission for Apex Health to text appointment reminders to the number listed above: **Y N N/A** *(please circle)*

SS# (for insurance only): _____ Email: _____

Family Physician/Primary Care Provider:_____ Provider Contact Number:_____

Emergency Contact (Name and Phone): _____ Relationship:_____

Is today's complaint due to a motor vehicle accident? **Y N** *(please circle)*

Have you had any X-rays / MRI's / CT's taken in the last 2 years related to today's complaint? **Y N** If "yes," where?

_____

FINANCIAL POLICY: I hereby consent to and authorize all treatment that may be advisable or necessary. In considering the amount of medical expenses to be incurred, I, the undersigned, understand that I am financially responsible for all expenses incurred for services provided, and payment is expected at the time of service. There will be a charge of **$30 for all returned checks.**

I give consent to keep my credit card information on file for any future authorized payments.

Apex Health Spine & Sport does accept certain Medicare Part B and standard Medicaid plans. Billing and payments required for in-plan Medicare Part B and Medicaid programs will be handled according to plan policy for patients currently eligible/active in such plans with patient-responsible portion of the charges due at time of service. I hereby authorize the provider to release all medical information necessary to process my claims. I will immediately notify this office of any changes in my insurance policy. I understand that failure to immediately notify this office of policy changes may result in my being responsible for payments related to dates of service where policies had changed.

MISSED APPOINTMENTS: While we are sensitive to the fact that an emergency may occur in a rare instance, last-minute 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**. I understand that cancellation of an appointment or failure to show for an appointment with **less than 24 hours prior notice** will result in a **$30 charge.**

RELEASE OF RECORDS: 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 additionally authorize Apex Health Spine & Sport, at its discretion, to verbally discuss or provide initial and follow-up reports to my primary healthcare provider or other providers involved in my care. This permission will remain in effect until revoked by me in writing.

I have read and fully understand each section of this agreement. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

Signature of Patient / Guardian (if patient is a minor) Date

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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.

_____

_____

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

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

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? _____

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Patient Name: _____ Date:_____

The goal of Apex Health Spine & Sport is to help guide and enable patients to gain control of their health. To attain this, we believe communication is key. There are often topics that are hard to understand, and we hope this document will clarify some of those issues for you. Please read the paragraphs below. If you have any questions, please feel free to ask one of our staff members for clarification.

Chiropractic Therapy often involves, but is not limited to, joint manipulation or mobilization of the spine and/or extremities, myofascial therapy to muscles and connective tissues, stretches, exercise instruction, and use of modalities such as decompression therapy, laser therapy, and electrical stimulation therapy.

General Risks of Care:

Chiropractic therapies and clinical procedures are usually beneficial and seldom cause any problems. However, as with any healthcare procedure, there are certain complications which may arise during evaluation or the administration of chiropractic therapy. These complications include but are not limited to: soreness and stiffness following treatment, fractures, disc injuries, dislocations, muscle strains, bruising, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke.

Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic seems to indicate that if there is a causal relationship, occurrence is rare. Unfortunately, there is no recognized reliable screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The Doctor will make every reasonable effort during examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

Other Treatment options:

Other treatment options for your condition may include the following: medical prescriptions such as anti-inflammatories, muscle relaxers, and analgesics; injections; physical therapy; or surgery.

Risks of Remaining Untreated:

Remaining untreated may lead to worsening of condition or the development of additional complaints/complications related to the current condition. Remaining untreated over time may lead to more difficulty in therapeutic intervention and/or permanent complications.

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 of the patient named above. I've read and fully understand the paragraphs above and hereby grant permission for my child to receive evaluation (including x-ray studies) and treatment. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

By signing below, I state that I have read and fully understand the above statements to my satisfaction. Having been informed of the risks, I hereby give my consent to evaluation (including x-ray studies) and treatment. This consent applies to all future evaluations and treatments at Apex Health Spine & Sport. Additionally, 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/Guardian Signature: _____ Date: _____