APEXHEALTH

SPINE & SPORT

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

I give permission for Apex Health to text appointment reminders to the cell phone number listed above: ◯ Yes ◯ No

SS# (Medicaid and Medicare patients only): _____

How did you hear about us? _____

Emergency Contact: _____ Contact Phone: _____

Is today's complaint due to a motor vehicle accident? ◯ Yes ◯ No

Have you had an X-ray, MRI, or CT taken in the last 2 years related to today's complaint? ◯ Yes ◯ No If "yes," where at?

_____

Primary Care Provider: _____ Provider Phone: _____

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 is a "non-participating provider" with Medicare Part B. As such, qualifying Medicare Part B patients will pay Apex Health Spine & Sport the allowed Medicare non-participating provider fees at the time of service. We will file claims with Medicare for the duration of the patient's Active Care. Medicare reimbursement payments will then go directly to the patient in amounts determined by the Medicare reimbursement fee schedule once the deductible is met.

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 48 hours in advance**. I understand that cancellation of an appointment or failure to show for an appointment with **less than 48 hours prior notice** will result in a **$35 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.

Patient/Guardian Signature: _____ **Date:** _____

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Patient Name: _____ **Date:** _____

PATIENT HISTORY

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 exercise regularly? ◯ Yes ◯ No

If "yes," how many times per week and what type? _____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No If "yes," what is your due date? _____

REVIEW OF SYSTEMS

Are you *currently* experiencing any of the following symptoms/conditions? Please circle Y or N.

Y N	Fever/Chills	**Y N**	Chest Pain	**Y N**	Depression
Y N	Headaches	**Y N**	Shortness of Breath	**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**	Joint Swelling	**Y N**	Blood Thinner/Blood Clots
Y N	Persistent Cough	**Y N**	Arthritis	**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? _____

APEX HEALTH

SPINE & SPORT

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.

CHIROPRACTIC THERAPY

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, rehab/exercise instruction, and use of modalities such as decompression therapy, laser therapy, dry needling, and electrical stimulation therapy.

GENERAL RISKS OF CARE

Chiropractic therapies and clinical procedures seldom cause any problems. However, as with any healthcare procedure, there are certain complications which may arise during the 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 legal 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:** _____