SPORTS & SPINAL
WELLNESS CENTER

DATE:_____

Name:_____ Preferred Nickname :_____

Address:_____ City:_____ State:_____ Zip_____

Social Security # _____-_____-_____ Marital Status: S M Spouse: _____

DOB: ____/____/_____ Sex: _____Male _____Female

Home Phone: (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone: (_____)_____-_____ Cell Carrier: _____

Please check your contact preference: ___Home ___Cell ___ Text ___ E-mail

E-mail address: _____

Emergency Contact: _____ Phone Number: (_____)_____-_____

Occupation: _____ Employer: _____

Primary Care Provider: _____

Whom may we thank for referring you? _____

List of Medications:

_____

_____

List of Surgeries:

_____

_____

List of Allergies:

_____

Patient/Guardian Signature_____

INJURY OR CONDITION INFORMATION:

Will your visit today be for: _____ Injury/Pain _____ Wellness _____Sports Performance

Was your injury related to an accident: ____ Yes ____ No If yes, was it ___ work or ___auto

What is hurting today? _____

When did it start? _____ **How did it start?**_____

Describe you condition: _____

_____

Rate your symptoms: (0=best, 10=worst) _____/10

With time is your condition: _____getting better _____getting worse _____same

What makes your symptoms better?

___ Standing ___Sitting ___walking ____Bending ___Lying down ____exercise ____nothing

What makes your symptoms worse?

___ Standing ___Sitting ___walking ____Bending ___Lying down ____exercise ____nothing

What treatments have you tried for this condition? ___none ___ heat ____ice ____medicine

____massage ____Chiropractic ____physical therapy ____ acupuncture ____surgery

Have you had any recent imaging of this area? ____X-ray ____MRI ____Other

Does your condition interfere with your activities including work duties, daily life, social or recreation? ____No ____Yes: please list activities that you have difficulty with? _____

_____

Have you had any of the following: (circle all that apply)

Cancer	Diabetes type 1	Diabetes type 2	Fractures	Headaches	Heart Disease
Herniated Disc	High Blood Pressure	High Cholesterol	Lupus	Lyme Disease	
Multiple Sclerosis	Osteoporosis	Pacemaker	Pregnant	Rheumatoid Arthritis	
Sjogren's disease	Stroke				

SPORTS & SPINAL WELLNESS CENTER
INFORMED CONSENT TO EVALUATE AND TREAT

PRINT NAME: _____ DATE OF BIRTH:_____

I understand and am informed that, as in all healthcare, in the practice of chiropractic there is a small inherent risk of injury which includes but not limited to, muscle strains, sprains, fractures. Dislocation, intervertebral disc injury and cardiovascular accidents. I understand that my doctor will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interest considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time. I have read and understand the preceding statements and hereby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

Signature: _____
Guardian Signature for a minor: _____

NOTICE OF PRIVACY FOR PATIENT'S PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information is kept private except uses involved in your healthcare. I understand that this information serves as: a basis for planning my care and treatment, a means of communication between my healthcare providers, a source of information for applying my diagnosis and prior health information to my bill, a means by which a third-party payer can verify that services billed were actually provided, a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that: I have the right to object to the use of my health information for directory purposes, I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and the that the organization is not required to agree to the restrictions requested. I understand that: I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in the reliance thereon. I have the right to request a copy of my records. I understand this request will be in written form and I must allow 14 day notice. I also understand there is a fee to obtain copies. I understand that the information used or disclosed pursuant to the authorization may be subject to being disclosed again by the recipient and that this information will no longer be subject to protection as protected health information.

With my consent, the Sports & Spinal Wellness Center may send mail to my home or call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and information pertaining to my clinical care.

Signature: _____ DATE: _____

SPORTS & SPINAL WELLNESS CENTER
FINANCIAL POLICY

Please initial each line:

_____ **Missed or late canceled appointments**: I am aware I will be charged $25 if I fail to show up for my appointment or cancel within 24 hours.

_____ **Workers Compensation or No Fault**: Sports & Spinal Wellness Center does not participate with NY Workers Compensation Program or No Fault cases. I understand that if my health insurance denies coverage for care at this office due to a prior WC or NF case, I am 100% responsible for payment of these services if full.

_____ **Individual Health Insurance**: I understand my insurance policy is an agreement between me and my insurance company, not between my insurance company and this office. It is my responsibility to call my insurance company to verify my coverage for chiropractic care at this office. All benefits quoted by SSWC are a general outline and not a guarantee of payment. As a courtesy, SSWC will submit all eligible charges to the insurance company. I understand that I am 100% responsible for all services rendered that are not covered by my insurance.

_____ **I understand I am financially responsible for services not covered by my insurance company, workers compensation or auto insurance companies. If any settlement, either by court, arbitration or any other means is longer than 90 days, I agree to pay my outstanding charges in full to Sports & Spinal Wellness Center. If the event of default on payment, I will pay in addition to the amount due, collection cost and attorney fees and service charges.**

Patient Name: _____ **Date:** _____

Signature: _____