PATIENT INFORMATION Full Name:	Preferred Name:
Date of Birth:	Address:
Primary Phone Number: _____ Secondary: _____	Apt #/City/State/Zip:
Email:	
Emergency Contact Name & Phone #:	
Marital Status:	Occupation:
Were you referred by anyone?	List any/all current health complaints
List all current medications (including blood thinners) _____ _____ _____ _____	_____ _____ _____ _____
List any major surgeries/injuries/operations: _____ _____ _____ _____	Have you had any prior treatment before? _ Chiropractor _ Massage Therapy _ Acupuncture _ Other: _____
Who is financially responsible for my care?	Name of Health Insurance:

Is this visit related to an accident/work injury? **Y _ N_** Workers Comp ____ Motor Vehicle Collision ____ **Date of Injury**: _____ **Primary** Insurance Name: _____ **Claim Number**: _____ Claim Manager Name & Phone #: _____ **(MVC Only)** Third Party Insurance Name: _____ Third Party Claim Number: _____ Claim Manager Name & Phone #: _____ *If no personal injury protection is available and/or claim is not open we require health insurance then payment at the time of service.	Minor Consent-(**skip to bottom signature if not applicable)** I hereby authorize Dr Baker and/or the massage therapist(s) to administer care, as deemed necessary to my, _____ (indicate relationship to child). Parent Name: _____ Signature: _____ Date: _____ **By signing, I confirm that the information I provided is true and accurate to the best of my knowledge.** ***ALL Patients Signature:** _____ **Date:** _____

Health History (Check all that apply)

Musculoskeletal

_ Osteoporosis
_ Arthritis
_ Joint Replacement
_ Dislocations
_ Fractures/Broken Bones
_ Disc Herniation/Rupture
_ Stiffness/Swelling
_ Headaches/Migraines
_ Jaw Pain/TMJ
_ Strains/Sprains
_ Problems Walking
_ Scoliosis
_ Bone/Joint Disease
_ Tendinitis
_ Bursitis
_ Chest, ribs, abdominal pain
_ Back/Hip Pain
_ Neck, Shoulder, Arm Pain
_ Leg/Foot Pain
_ Spasms/Cramps

Medical History

_ Cancer Type:
_____
_ Diabetes Type:
_____
_ High Blood Pressure
_ Low Blood Pressure
_ High Cholesterol
_ History of Falling
_ Stroke or TIA
_ Epilepsy
_ Emphysema
_ Kidney Disease
_ Seizures
_ Pacemaker
_ Numbness/Tingling/
_ Fatigue
_ Chronic Pain
_ Sleep Disorders
_ Sinus Problems
_ Rashes
_ Allergies
_ Athletes Foot
_ Pressure Sores
_ Dizziness
_ Heart Condition
_ Lymphedema
_ Hormone Replacement
Surgery

_ Blood Clots
_ Asthma
_ Varicose Veins
_ Deep Vein Thrombosis
_ Crohn's Disease
_ Osteoporosis
_ Ulcers
_ Paralysis
_ Herpes/Shingles
_ Cerebral Palsy
_ Multiple Sclerosis
_ Spinal cord injury
_ Hysterectomy
_ IUD
_ Pelvic Inflammatory Disease
_ Endometriosis
_ Fibromyalgia
_ Hemophilia
_ Colitis
_ Indigestion
_ Constipation
_ Communicable Disease
(HIV, Hep C)
_ Drug Use: _____
_____

_ Alcohol Use: _____
_____
_ Caffeine Use: _____
_____
Allergies (Specify):
_____
_____
_____
_ Cosmetic Surgery (Specify):
_____
_____
_ Pregnancy (If current, due date):
_____

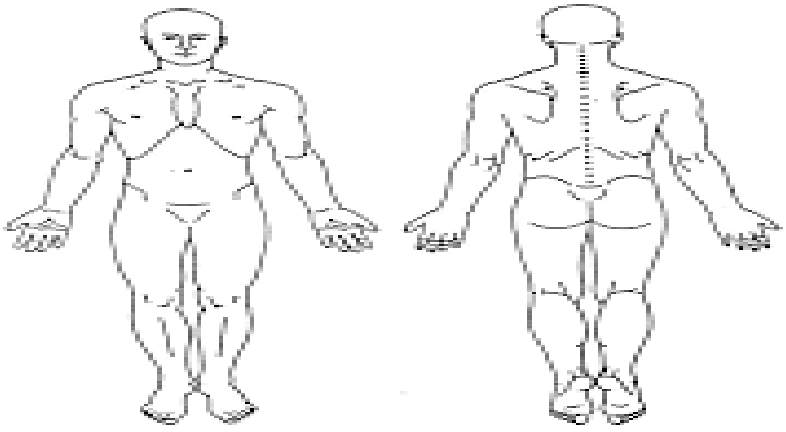
How much physical activity do you get in a week?
_____

Changes in Health

_ Decreased Coordination
_ Nausea/Vomiting
_ Appetite Changes
_ Hearing Loss
_ Vision Changes
_ Bowel/Bladder Changes
_ Depression/Mood Changes

List any other health information you would like us to be aware of
_____
_____

- **Please indicate where you are feeling any discomfort** -



Acknowledgment of Receipt of Privacy Practices (HIPPA)

I understand that as part of my health care, PrimeSpine originates/maintains paper and/or electronic records describing my health history and treatment plans. I understand that this information serves as a basis for planning my care and treatment, communication among the health professionals who contribute to my care, information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I understand that I have the following rights and privileges: to review this notice prior to signing, to object to the use of my health information for directory purposes, and to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that PrimeSpine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that PrimeSpine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information: I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Insurance Policy

I hereby assign all medical benefits to which I am entitled to Primespine Chiropractic & Massage in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Primespine strongly encourages me to verify my benefits with my insurance company. Should I decide not to check my benefits, I understand that any fees accrued with that insurance company does not pay will be my responsibility. Primespine will verify your benefits and go over your benefit details on your first or second visit. All payments are due at the time of service.

Workers Compensation

Primespine will bill your *open, approved* claim. Please be advised that in the event your claim is denied you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated with Primespine, you are responsible for tracking your authorized visits. In the event you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible. If the claim is not open/allowed for billing or the transfer of care has not been approved, your private health insurance does not cover any treatments, the balance will be my responsibility.

Motor Vehicle Collision

Primespine will bill my insurance company on my personal injury protection coverage, if available. If coverage is not available, we require health insurance then payment at the time of service. Patients without PIP coverage are required to pay a portion of treatment upfront, the remaining balance is paid when the patient receives their settlement money after the treatment is finished and the claim is settled.

Scheduling & 24-Hour Notice (Applies to massage appointments only)

We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-Hour notice from the time your appointment is scheduled. *If you fail to attend your scheduled appointment and do not provide us with prior notification, **you will be assessed a fee of $45**.*

If you fail to show/communicate to our office for two consecutive sessions, we will consider you discharged from our care and we will cancel all scheduled appointments going forward.

I have read and fully understand the above statements, and accept the terms of this consent. All questions regarding the doctor's/massage therapist(s) objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic/Massage Therapy care on this basis.

Patient/Parent Signature: _____ Date: _____