PRINT

NEW PATIENT INTAKE QUESTIONNAIRE

SUBMIT RESET

Confidential Patient Information

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: M ○ F ○ Non-Binary ○

Address: _____

Email: _____ Cell-phone number: _____

Home-phone number: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Phone number: _____ Relationship: _____

Emergency contact address: _____

Information for Financially Responsible Party (if not Patient):

Name: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

Address: _____

Insurance and Referring Physician Information:

Do you have health insurance? Yes ○ No ○ Insurance company: _____

ID #: _____ Group #: _____

Referring Physician_____ Primary Physician (If different): _____

Are you currently receiving treatment for this problem? Yes ○ No ○ Physician name: _____

Physician address: _____

Physician phone number: _____ How were you referred to us? _____

HEALTH HISTORY QUESTIONNAIRE

Briefly describe the problem you are here for and how it started: _____

_____

_____

Chronic _____ **Acute** _____ **New injury** _____

Similar problem on other occasions? ___ Yes ___ No **Most recent was, when?** _____

Date of injury or onset of symptoms: _____**Surgery performed /Date**_____

Is today's visit due to a work related or auto accident injury? ____ No Yes_____ Date_____

Symptoms appeared:____ Gradually ____ Suddenly **Please mark pain location on the body diagram below:**

Feelings of: ___ **P**ain ___ **S**welling ___ **W**eakness____ **N**umbness /**T**ingling

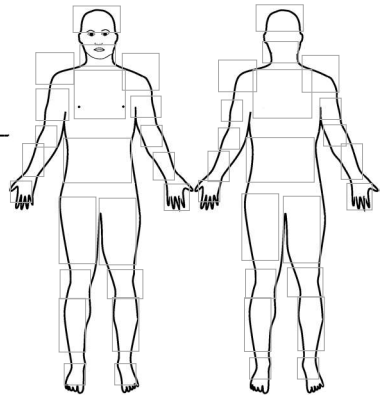
If pain: ____ Local (or radiates into) ___ Arm ____ Leg

Describe your pain: Aching _____Burning_____ Dull_____ Sharp _____ Other: _____

Level of pain at best (0-10): _____ (0=no pain ; 10= extreme pain)

Level of pain at worst (0-10): _____

Current pain level (0-10): _____



Does the pain wake you at night? ____ Yes ____ No

If yes, can you get back to sleep? ____ Yes ____ No

Unexplained weight loss: ____ Yes ____No

What, if anything, makes your symptoms WORSE? _____

What, if anything, DECREASES your symptoms? _____

Diagnostic TESTS/Imaging for THIS problem? ____ MRI ____Ultrasound____ CT Scan____X-Ray ____ Bone Scan

What, if known, are the results of the above tests? _____

Have you had previous chiropractic and / or physical therapy care? ____ No____Yes

If YES, for what problem? _____

General Health : ____ Good ____ Fair ____ Poor **Health Problems** : _____

Please list ALL past surgeries/ injuries (year) : _____

Do you have a pacemaker? ____No ____ Yes

History of falls? ____ No ____Yes **Balance Problems ?** ____ No ____ Yes

Please list medications currently taken : _____

_____

Your Goals : _____

Informed Consent

Physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Please read the form below and provide your consent.

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness / Bruising: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fracture/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.
Treatment Results. I also understand that there are beneficial effects associated with these treat ment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including Physical Therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of the doctor's choosing. I have read or have had read to me the above explanation of treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

I AGREE ☐ Signature or Full Name of Consenting Party: _____

Assignment of Benefits

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims or that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above clinic. This agreement will remain in effect until all money owed to the above-named clinic is paid in full. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

I AGREE ☐ Signature or Full Name of Consenting Party: _____

Contracted Insurances

If we are contracted by your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible, co-insurance and non-covered services you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and / or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and / or preauthorization may result in a lower payment from the insurance company. You are responsible for all charges not paid by your insurance company.

I AGREE _____ Please Initial: _____

Non-Contracted Insurances

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and / or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and / or pre-authorization may result in a lower payment from the insurance company.

I AGREE _____ Please Initial: _____

Payment if you have no insurance

Full payment is due at the time of service. Please consult the front desk and / or therapist as to the price per treatment.

I AGREE _____ Please Initial: _____

Financial Agreement

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. As a courtesy, my insurance company will be billed by the clinic. I agree in a current manner and, in accordance with the terms and conditions of Pro-X Orthopedic Spine and Sports Therapy, any balance to said professional fees over and above third party reimbursement, including deductibles, co-payments, exclusions or denials. I understand that if treatment is suspended or terminated, any fees for professional services rendered will be due and payable upon request. I understand that any payment which is delinquent (i.e. following 30 days from request), may result in a 1.5% per month assessment on the remaining balance and that I will be fully responsible for any legal / collection or attorney's fees, if it becomes necessary to resolve the outstanding balance. **A service charge of $100 may be assessed for all no show and cancellations done less than 24 hours prior to a scheduled service.**

I AGREE _____ Signature or Full Name of Consenting Party: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Account ability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.
I have received, read and I understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Our Address:
Pro-X Orthopedic Spine & Sports Therapy
28210 Dorothy Drive, Agoura-Hills CA 91301
Phone – 818-532-7600
Fax – 818-532-7694
Email – frontdesk@proxtherapy.com

Please review the Notice of Privacy Practices in the next page before acknowledging.

I ACKNOWLEDGE _____ Signature or Full Name of Acknowledging Party: _____

Complete information about your rights under "HIPAA" and for filing a complaint please visit The US Department of Health & Human Services Website. For filing a complaint please go here

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.
As required by "HIPPA", we have prepared this explanation of how we are required to mention the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for your payment
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to requested restriction.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to chance the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice Privacy Practices from this office. You have recourse of you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201
Ph: (202) 619-0257 Toll Free: 1-877-696-6775