WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____
Street Apt# City, State, Zip

Phone # (H)_____ (W) _____ (Cell) _____

What phone # is best for us to contact you? (H) (W) (C)

Date of Birth: _____ Sex: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other _____

Ethnicity ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____

Phone #: (H) _____ (W) _____ (Cell) _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Other _____
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

PROTECTED HEALTHCARE INFORMATION AUTHORIZATION
FROM_____ TO _____ (5 YEAR)

Consent to Care:
I hereby authorizeThomas E. Eidson, PLLC, a Professional Medical Corporation, or the designee, to examine and/or treat me or the patient's condition as they deem medically appropriate/necessary. Initial:_____

Records Release: Insurance Carriers and other Payors:
I hereby authorizeThomas E. Eidson, PLLC to use, disclose and/or discuss information from my health record to any insurance company, Health plan, HMO, no fault carrier, worker's compensation carrier, Medicare/its agents, Optimum Healthcare, my employer (worker's compensation), Gateway EDI (electronic insurance billing) or any other payor, any information, including my complete health records, needed to determine benefits for services provided by or on behalf of Thomas E. Eidson, PLLC. Initial:_____

Records Release: Referring Physician and / or Primary Care Physician
I hereby authorizeThomas E. Eidson, PLLC to use or disclose any information from my health record to _____ my referring physician and / or my Primary Care Physician _____, or any other medical facility. Initial:_____

****Records Release: Spouse and / or Family Member (optional)****
I hereby authorize Thomas E. Eidson, PLLC to use or disclose any information from my health record to the following listed people:

1.)_____ Relationship:_____ 2.)_____ Relationship:_____

Assignment of Benefits
I hereby assign the authorized benefits and direct that payments under the insurance policy or health benefits plan to be made directly to Thomas E. Eidson, PLLC for any services rendered to me by or on behalf of Thomas E. Eidson, PLLC. Initial:_____

Financial Responsibility
I acknowledge and accept responsibility for any and all charges incurred for services rendered to me and / or my dependents. I agree to pay any legal services/collections fees necessary to collect for services should I default my obligation. It is agreed by me as the responsible party to see, the bill is paid in a reasonable amount of time. As a courtesy, Thomas E. Eidson, PLLC has agreed to bill my insurance plan, but I remain responsible for paying any and all bills, if the insurance company does not pay in a 90 day period of time. In accordance with the contract of your insurance company and as well as requirements of the provider by the insurance company. Initial:_____

Communication Release:
I hereby authorizeThomas E. Eidson, PLLC to communicate any messages concerning my Protected Health Information to my home phone number, and / or my cell number. I authorize you to leave messages regarding appointments on voicemail. Yes / No Initial:_____

Rights of the Individual:
(1) You may refuse to sign this authorization (2) You may inspect information used or disclosed under this authorization.
I understand that information disclosed under this authorization maybe be disclosed again by this organization and it may not be possible to ensure your rights of protection once Thomas E. Eidson, PLLC has disclosed it to another party. I understand I have the right to revoke these authorizations, with proper notification to Thomas E. Eidson, PLLC, Privacy Official in writing. Initial:_____

Signature of Patient or Patient Representative:_____**Date:**_____

If the patient is a minor, state their name:_____ **Your Relationship to minor:**_____

OFFICE POLICY EXPLANATION

Our office will be pleased to accept your insurance assignment as soon as your coverage is verified by our insurance manager. We will file your claim and assist you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1.) We will bill your insurance for every visit that you receive treatment in this office.
2.) You must pay your insurance co-pay at each visit or you may pre-pay for visit co-pays.
3.) OUR OFFICE DOES NOT GUARANTEE THAT YOUR INSURANCE WILL PAY. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for any reason your insurance claim is denied, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.
4.) Our office WILL NOT enter into a dispute with your insurance company over your claim. THIS IS YOUR RESPONSIBILITY AND OBLIGATION.
5.) **XRAY QUESTIONNAIRE:** ☐ There is a possibility that I may be pregnant at this time ☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time. ☐ I request that x-ray films not be taken because:_____
_____
6.) All x-rays and patient records are to remain permanent records at **Thomas E. Eidson, PLLC.** Copies of records can be made at an additional charge.
7.) **After Hour Emergencies.** Should you feel you have an urgent need for medical care when our clinic is not open, please call 911 or go to your nearest urgent care facility.
8.) If you are being treated for a work-related injury or auto accident you are to keep appointments as recommended to you by your treating doctor. If you fail to do so, your doctor has the right to release you from care at this clinic.

Please sign below to acknowledge that you have read the above clinic policies, understand them, and agree to them.

_____ _____
Patient signature (date) (please print your name)

If the patient is a minor, state their name:_____ **Your Relationship to minor:**_____

HealthQuest
Physical Medicine

INFORMED CONSENT

Doctor-Patient Relationship in Spinal Manipulation and Therapy

Spinal Manipulation

Spinal Manipulation seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Spinal Manipulation

ANALYSIS

A doctor conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Spinal Manipulation and ancillary procedures may be given in an attempt to restore spinal integrity. It is the premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. ***Due to the complexities of nature, no doctor can promise you specific results.*** This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Every Spinal Manipulation patient should be mindful of his own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your doctor works in conjunction with other physicians to diagnose your condition, but you are responsible for the final decision to treat.

INFORMED CONSENT FOR SPINAL MANIPULATION AND RELATED CARE

In coming to the doctor, a patient gives the doctor permission and authority to care for the patient in accordance with the Musculo- Skeletal tests, diagnosis and analysis. The Spinal Manipulation or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.

Specific Risk Possibilities Associated with Spinal Manipulation are:

Stroke: Stroke the most serious complication of Spinal Manipulation. It is rare. According to the journal of CCA, vol. 37, no.2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which is temporary or permanent brain dysfunction. On extremely rare conditions, death occurs.

Soreness: Spinal Manipulation is sometimes accompanied with post treatment soreness. This is normal, but please advise your doctor of the soreness.

Soft Tissue Injury: Occasionally, Spinal Manipulation may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause a rib injury or fracture. Precautions such as pre-adjustment X-rays are taken in cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. These are rare, but should be reported, as well, as other side effects you may be experiencing.

RESULTS

The purpose of Spinal Manipulation is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Spinal Manipulations. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Spinal Manipulation. Many medical failures find quick relief through Spinal Manipulation. In turn, we must admit that conditions which do not respond to Spinal Manipulation care may come under the control or be helped through medical science. The fact is that the science of Spinal Manipulation and medicine may never be so exact as to provide definite answer to all problems. Both have made great strides in alleviating pain and controlling disease.

I have read and understand the foregoing. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, Spinal Manipulation, Therapy or any clinic services that he deems necessary in my case. I further authorize him to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the office, the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, but not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE SPINAL MANIPULATION AND THERAPY ADMINISTERED.

Patients Printed Name _____ **Today's Date** _____

Patients Signature _____ **Parent/Guardian Signature if Minor** _____

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

HealthQuest Physical Medicine reserves the right to modify the privacy practices outlined in the notice.

Signature
I have read and/or received a copy of the Notice of Privacy Practices for HeathQuest Physical Medicine.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult unable to sign this form)

_____
Relationship of Patient Representative to Patient