

Patient Information Sheet



ELITE PERFORMANCE
CHIROPRACTIC

Name _____
Today's date _____ Date of Injury _____
Address _____
City _____ State _____ Zip _____
Sex (M) (F) Age _____ Birthdate _____
Occupation _____
Employer _____
We may reach you at: Home _____
Cell _____ Work _____
E-mail address _____
In case of an emergency, contact _____
at _____ or _____

Insurance Co. _____
ID# _____
Group # _____ Effective Date _____
If you're not the policy holder, provide the following:
Holder's name _____ Relation _____
Holder's Birthdate _____ SS# _____ - _____ - _____
Additional Coverage (Y) (N) Company _____
How did you hear us? _____

Patient's Condition

Reason for visit _____ When did symptom(s) appear _____
How did it occur: gradually () suddenly () Are symptom(s) constant (Y) (N) How long does it last _____
Activities or foods that intensify symptom(s) _____ alleviate symptom(s) _____
Have symptoms been getting worse since onset (Y) (N) better (Y) (N) or the same (Y) (N)
Has this ever happened before (Y) (N) What did you do for it then _____
Have the symptoms affected your daily activities (Y) (N) How _____
Are there other symptoms you feel might be related _____
Have you or are you currently receiving treatment for this problem (Y) (N) By whom _____
Are there any specific goals you wish to achieve by seeking treatment _____

Are symptoms the result of an accident (Y) (N) Type (Auto) (Work) (Other _____) Date of accident ___/___/___
Have you reported your accident to (Auto Ins. _____) (Work Comp _____) (Employer _____) (Attorney _____)
Can you provide us with a copy of an accident report or someone to contact for this (Y) (N) _____
Are you planning, or in the process of seeking damages for this accident (Y) (N)
If Yes, you may be asked to fill out a separate patient information sheet

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to the physicians of Elite Performance Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Printed Name _____ Patient's Signature _____

Legal Guardian's Printed Name _____ Legal Guardian's Signature _____

Translated By _____ Physician's Signature _____ Date _____

Patient Health History

Have you seen a chiropractor before (Y) (N)

If yes, for what _____

Date of most recent physical _____ Blood Test _____

Please circle if you have had any of the following testing:

X-ray, MRI, CT, Bone Scan, Other _____

Area Viewed _____ Date: _____



General

- Yes No Fever
- Yes No Night Sweats
- Yes No Loss of Sleep
- Yes No Chronic Fatigue
- Yes No Rapid Weight Loss
- Yes No Swollen Glands
- Yes No Allergies
- Yes No Rashes/Open Wounds
- Yes No Changes in Mole(s)
- Yes No Skin Cancer
- Yes No Bruise Easily
- Yes No Bleeding Disorders
- Yes No Anemia
- Yes No Diabetes
- Yes No Cancer
- Yes No Thyroid Disease/Cancer

Eye, Ear, Nose, and Throat

- Yes No Eye Ailments
- Yes No Prescription Glasses
- Yes No Recurrent Ear Infection
- Yes No Loss of Hearing/Deafness
- Yes No Nosebleeds
- Yes No Sinus Trouble
- Yes No Dental Trouble
- Yes No Hoarseness

Respiratory

- Yes No Difficulty Breathing
- Yes No Chronic Cough
- Yes No Excessive Phlegm
- Yes No Blood in Phlegm
- Yes No Wheezing/Asthma
- Yes No Pneumonia
- Yes No Tuberculosis

Cardiovascular

- Yes No Irregular Heartbeat
- Yes No High Blood Pressure
- Yes No Pain in Chest
- Yes No Previous Heart Ailments
- Yes No Ankle Swelling
- Yes No Varicose Veins
- Yes No Stroke
- Yes No Angina

Gastrointestinal

- Yes No Diarrhea
- Yes No Constipation
- Yes No Difficulty Swallowing

- Yes No Excessive Gas

- Yes No Frequent Heartburn
- Yes No Frequent Nausea
- Yes No Ulcers
- Yes No Black or Bloody Stool
- Yes No Gallbladder Ailments
- Yes No Hernia
- Yes No Hemorrhoids

Genitourinary

- Yes No Frequent Urination
- Yes No Painful Urination
- Yes No Blood in Urine
- Yes No Kidney Disease
- Yes No Urinary Disease
- Yes No Incontinence
- Yes No Hesitation
- Yes No Wake to Urinate ___/night
- Yes No Sexual Difficulties

Men Only

- Yes No Testicular Swelling/Pain
- Yes No Prostate Ailments

Woman Only

- Yes No Having Regular Periods
_____ Date Last Period Began
- Yes No Painful Periods
- Yes No Excessive Flow
- Yes No Irregular Cycles
- Yes No Hot Flashes
- Yes No Abnormal Bleeding
- Yes No Pre-menstrual Syndrome
- Yes No Pregnant/Due ___/Child# ___

Habits

- Yes No Smoking ___ packs/day
- Yes No Drinking ___ oz/day
- Yes No Alcohol or Drug Abuse

Neurological

- Yes No Weakness
- Yes No Tremors
- Yes No Headaches/Migraines
- Yes No Dizziness
- Yes No Epilepsy
- Yes No Numbness/Tingling
- Yes No Arm/Leg Pain

Musculoskeletal

- Yes No Herniated Discs
- Yes No Swollen Joints
- Yes No Painful Joints
- Yes No Muscle Aches/Cramps

- Yes No Arthritis _____

Exercise (circle one)

Not at all Occasionally Regularly

Family History (immediate family mostly, and indicate whether ailment is on your mother or father's side)

- Yes No Diabetes
- Yes No Thyroid Disease/Goiter
- Yes No Tuberculosis
- Yes No Kidney Disease
- Yes No Liver Disease
- Yes No High Blood Pressure
- Yes No Heart Disease
- Yes No Cancer
- Yes No Muscle/Bone/Nerve Dis.

Medication(s)

Name	Dose	Reason

Supplements

Name	Dose	Reason

History of Surgeries

Date	Area	Any Implants

History of Hospitalization(s)

Date	Reason	Prognosis

Pain Diagram and Visual Analog Scale

Please read carefully:

Mark the areas on the diagram below that coincide with your pain. Include all the affected areas.

Use as many individual symbols as you'd like to describe the pain intensity.

Indicate radiation of pain by drawing an arrow (→) from the origin of pain to where it stops.

Mark your symptoms on the pain chart below with the appropriate symbols:

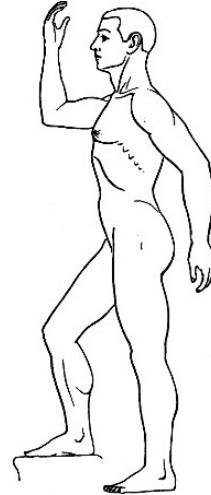
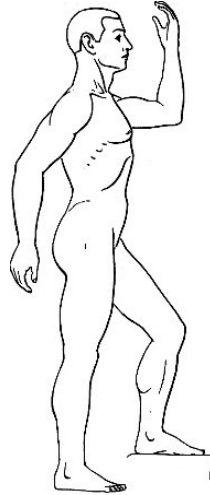
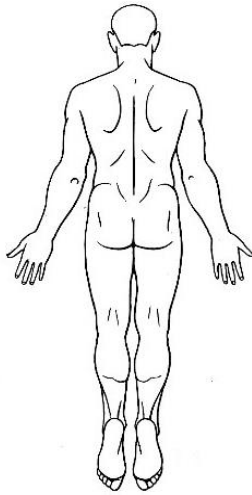
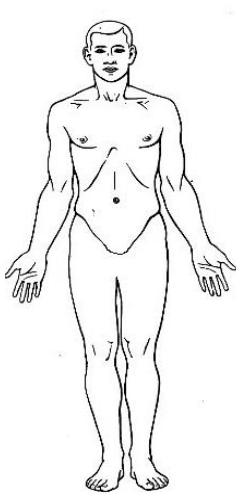
Aching
XXXXX

Numbness
OOOOOO

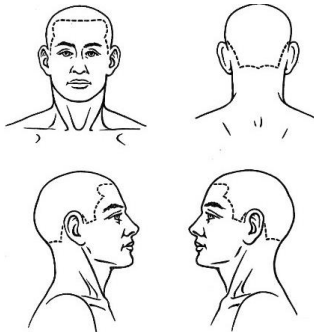
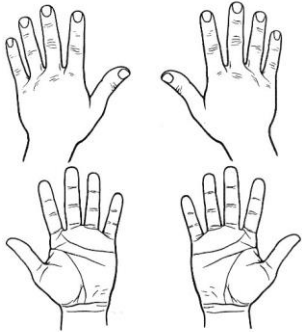
Tingling
.....

Sharp
/////

Other (Please specify)



HEADACHES ↓



Place an "X" on the line below rating the severity of pain:

NO PAIN

WORST PAIN IMAGINABLE

TODAY: ☺ ----- ☹

WORST: ☺ ----- ☹

BEST: ☺ ----- ☹

Informed Consent to Chiropractic Health Care

By reading and signing this form, I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic and qualified staff members at Elite Performance Chiropractic(EPC) and/or other licensed doctors who now or in the future work at EPC.

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 such as Soreness: 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. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. One in a million is about the same chance as getting hit by lightning. One in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. 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. Finally, I am aware that the appropriate 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 treatment 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 chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery. Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Notice of Privacy Policy

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. If Applicable, we may disclose your health information, as deemed necessary by law, to: comply with state Workers' Compensation Laws, in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, pre-approved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restrictions on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with you physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available by us upon request, or at www.hcfa.gov/medicaid/hippa. Questions, concerns, and/or complaints should be directed to DHHS, Office of Civil Rights 200 Independence Ave., S.W. Room 509F HHH Building in Washington, DC 20201

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction Prior To My Signing This Consent Form. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Name _____ Signature _____ Date _____

Witnessed (and/or translated) by _____

FORM: OPFA OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality chiropractic and rehabilitation care affordable to everyone. The following is a statement of our office policy and financial policy, which we ask that you read, agree to, and sign before any treatment is rendered.

Most chiropractic/physical therapy insurances have limits and/or various degrees of co-payments. The treatment is recommended by our office is never based on what your insurance will pay; your treatment should not be governed by your insurance contract. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. **At the time of treatment, the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in our office. The patient/guarantor is responsible for all charges that are denied or unpaid by your insurance carrier.** If for some unforeseen reasons your insurance carrier has not made payment within 45 days, the patient/guarantor is responsible for these charges.

**** Cancellation Policy ****

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of one (1) business day notice. Our office does not accept cancellation or changes in appointments after-hours by voicemail; you must call during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the doctor or massage therapist.

***** Missed Appointment Fee *****

Missed appointment fee of \$105.00 for every doctor's appointment and \$120 for each massage will be charged to any patient who does not notify our office within one (1) business day to cancel or reschedule their appointment.

Regarding Insurance

If the patient has any insurance charges or maxes out of benefits, it is the patient's/guarantor's responsibility to be aware of it and provide the information. If this information is not provided at the time of service, the patient/guarantor will be responsible for the charges incurred. I understand my medical insurance is a contract between the insurance carrier and the patient, not between doctors and the insurance carrier. **Please note that NO individual in this office can predict exactly what amount your insurance will pay.** When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage, until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate in any way. In some cases, insurance companies use alternative benefits as a method of payment and not pay the total estimated amount. Therefore, do not hold us responsible for payments that a third party may refuse to pay.

Past-Due Accounts

I understand that I am financially responsible for all charges incurred in full by myself and/or my dependents. I agree that in the event my account is past due sixty (60) days from the date of service, it will be turned over to collection agency unless arrangements are made in advance. Monthly interest rate of 1.5% (18% APR) will be incurred for accounts sixty (60) days past-due. I agree that I am liable for all collection charges including but not limited to attorney and legal fees in the event my account was turned over to collection agency. A fee of \$25.00 will be charged on all returned checks.

Credit Card Authorization

I authorize automatic credit card transactions with the credit card I allow the front desk to use upon the first visit (or subsequent). This card will be automatically used for any transaction under the amount of \$250. Once insurance explanation of benefits are entered into our system, this credit card will be used for payment.

Insurance Signature Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me and my dependent and/or other health practitioners relating to all claims for benefits submitted on behalf of myself and/or my dependents. I agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents. I will be bound by this signature as though I had personally signed each claim. I hereby assign all medical, chiropractic, or physical therapy benefits to which I am entitled for this service to Dr. Malartsik or any physician of Elite Performance Chiropractic. A photocopy of this assignment is to be considered as valid as an original.

I have read, understand, and agree to the above Office Policies and Financial Agreements.

Patient Name _____

Patient Signature (parent or legal guardian if patient is a minor) _____ Date _____