Patient information

First Name:_____ Last Name:_____ Date:_____

Email:_____ Address: (street)_____

Home phone number:_____ (city,state, zip)_____

Cell phone number:_____ Best number to reach you: (H) (C) (W)

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

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

Occupation: _____Employer:_____

Employer Address:_____ Phone:_____

How did you hear about our practice?_____

Emergency Contact:_____Phone:_____ Relation:_____

Accident Information

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

If Auto or Work, has it been reported? ☐Yes ☐No If yes, to whom?_____

Insurance Information

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

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

Policy Holder Name: _____ Date Of Birth:_____

Relationship to you (if not yourself):_____ Phone:_____

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.

SIGNATURE:_____ DATE:_____

RECEIPT OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices of Northstar Integrated Health & Physical Medicine, SC.

☐ I wish to receive a paper copy of Privacy Notice.

☐ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____

☐ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

(x)_____ I acknowledge that it is the policy of Northstar Integrated Health & Physical Medicine, SC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

(x)_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Vicky Saieg, about my concerns.

Patient/Guardian Signature:_____ Date:_____

Witness (Office Staff):_____ Date:_____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I, _____(*print name*) have read and understand the foregoing.

_____ _____

Patient's Signature Date

X-ray Questionnaire (Women Only)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

- ☐ 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:

_____

_____

Date of beginning of last menstrual period: _____

_____ _____

Patient's Signature Date

Spinal Manipulation Consent

A patient coming to the doctor gives their permission and authority to care for them in accordance with appropriate testing, diagnosis, and decision making. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he is aware that such care may be contraindicated. It is the responsibility of the patient to report any known contraindications or adverse effects from any treatment or test they have received. It is also the patient's responsibility to report any future adverse effects they may experience.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, by binding arbitration under the current malpractice terms which can be obtained by written request.

Spinal Manipulation, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with manipulative care. The types of complications that have been reported secondary to maniplative care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with manipulative care, occurring at a rate between one instance per 1-2 million cervical spine (neck) adjustments. In these rare events, a vertebral artery could be injured which may lead to stroke.

Prior to receiving any spinal manipulation treatment at this clinic, a health history, physical examination, and possible diagnostic tests will be completed. These are performed to assess your specific condition, your overall health and, in particular, your spine health. These activities assist us in determining if spinal manipulation is needed, or if any further examinations or studies may be needed. In addition, they will help us determine if there is any reason to modify your treatment plan or provide you with a referral to another health care specialty. All relevant findings will be reported to you along with a treatment plan prior to beginning care.

I understand and accept that there are risks associated with spinal manipulation and give consent to the indicated examinations and diagnostics.

Patient Signature:_____ **Date:**_____

This notice is effective as of this date,_____, and will expire seven years after patient's final date of treatment at Northstar Integrated Health & Physical Medicine, SC.

Financial Policy

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. It is the patient's responsibility to pay their co-payment (usually a percent or fixed amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts Credit/Debit Cards, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation with our financial policy.
I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Signature:_____ Date:_____/_____/_____

PATIENT MISSED APPOINTMENT POLICY

It is our wish that each and every one of our patients receive the highest quality of care and service possible. Providing the best possible care gives our patients the best possible results and allows them to enjoy best quality of life. **Your Treatment Program** consists of a specific series of treatments given over a pre-planned time period. Quite simply, if you are unable to follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice by providing less than optimal care and it would also suggest that we did not care about the outcome of your treatment. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.

*2. If you become ill, we still want you to come in. **Physical Medicine Treatments** will help you recover more quickly and we would be happy to provide any general medicine treatment that may be necessary as well.*

3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.

4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.

5. All cancelled or missed appointments must be rescheduled and made up within one week.

6. There is a $20.00 service charge for no call/no show appointments.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

Health History

Primary doctor & location:_____ Last Physical: _____

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

❑Neck Pain/Stiff	❑Headaches	❑Chest Pain	❑Fatigue	❑Sleeping Difficulties
❑Back Pain/Stiff	❑Tension	❑Short of Breath	❑Rapid Weight Change	❑Bowel/Bladder Changes
❑Arm/Hand Pain	❑Fainting	❑Easily Exerted	❑Fever	❑Stomach Problems
❑Leg/Knee Pain	❑Dizziness	❑Asthma	❑Night Sweats	❑Anxiety
❑Pins/Needles-Arms	❑Loss of Smell	❑Constipation	❑Night Pain	❑Depression
❑Pins/Needles-Legs	❑Allergies	❑Diarrhea	❑Nausea	❑Loss of Memory
❑Light Bothers Eyes	❑Blurry Vision	❑Cold Feet	❑Loss of Taste	❑Loss of Smell

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

❑Hypertension	❑Hepatitis	❑Fractures	❑Rheumatoid Arthritis	❑Pneumonia
❑Heart Disease	❑Kidney Disease	❑Arthritis	❑Menstrual Problem	❑Scarlet Fever
❑Stroke	❑Liver Disease	❑Herniated Disc	❑Miscarriage	❑Mononucleosis
❑Diabetes	❑Thyroid Disease	❑Pinched Nerve	❑Vaginal Infection	❑Polio
❑High Cholesterol	❑Lung Disease	❑Migraines	❑Breast Lump	❑Tonsillitis
❑Emphysema	❑Bowel Disease	❑Prosthesis	❑Prostate Problems	❑Tuberculosis
❑Asthma	❑Bladder Disease	❑Osteoporosis	❑Aids/HIV	❑Typhoid Fever
❑Bronchitis	❑Parkinson's	❑Glaucoma	❑Sexually Transmitted	❑Rheumatic Fever
❑Cancer	❑Multiple Sclerosis	❑Cataracts	❑Gonorrhea	❑Psychiatric Condition
❑Allergies	❑Hernia	❑Chicken Pox	❑Anemia	❑Alcoholism
❑Ulcers	❑Appendicitis	❑Measles	❑Blood Disorder	❑Drug Dependency
❑Gout	❑Pacemaker	❑Mumps	❑Epilepsy	❑Suicide Attempt

*Other:*_____

Are you currently under any medical care? ❑Yes ❑No If yes, for what condition:_____

List any medications you are currently taking (include dosage and frequency):

_____

List all surgeries and/or hospitalizations(include types & dates):

_____

List any allergies:_____

List any supplements you currently take:_____

Is there a family history of any of the following conditions? (indicate which family member)

❑Heart Disease ❑Diabetes ❑Cancer ❑Arthritis ❑Other_____

Do you exercise: ❑Never ❑Daily ❑Weekly ❑Walk ❑Run Other Activities:_____-----_____

At work, are you mostly: ❑Sitting ❑Standing ❑Light Labor ❑Heavy Labor

Daily/weekly intake of the following: Caffeine_____ Alcohol_____ Cigarettes_____

***I certify that the above questions are accurate. I understand incorrect information can be dangerous to my health.*

SIGNATURE_____ DATE_____

ROS CHECKLIST:

Name_____Date_____

General-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Head-
- ☐ Headache/migraine
- ☐ Head injury
- ☐ Neck Pain

Ears-
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes-(Last Exam:_____)
- ☐ Vision Loss/Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks or floaters
- ☐ Glaucoma
- ☐ Cataracts

Nose-
- ☐ Stuffiness
- ☐ Discharge-Mucous
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat-
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

Neck-
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts-
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Regular self-exams
- ☐ Currently breast-feeding

Respiratory-
- ☐ Cough
- ☐ Sputum
- ☐ Coughing Blood
- ☐ Short of breath
- ☐ Wheezing
- ☐ Difficulty breathing

Cardiovascular-
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath(w/ exertion)
- ☐ Shortness of breath(lying flat)
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea/Vomiting
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Urinary-
- ☐ Pee too much
- ☐ Can't make it in time
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinent/Accidents
- ☐ Change in urine flow

Vascular-
- ☐ Calf pain w/ walking
- ☐ Leg cramping

Musculoskeletal-
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic-
- ☐ Easy bruising
- ☐ Easy bleeding

Endocrine-
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Psychiatric-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss