athletica
spine & sport

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Ph: 281-394-9100 Fax: 281-557-6513

*Today's Date:_____

PATIENT INFORMATION

Name: _____D.O.B:_____
Address: _____ City: _____State:_____ Zip:_____
Phone: (___)_____Email:_____
Marital Status: _____ Number of Children:_____
Employer: _____ Full-time or Part-time (circle one)
OR School: _____ Grade: _____
Emergency Contact:_____Relationship:_____Phone:_____

INSURANCE INFORMATION: This section must be completed in order to file a claim

Insurance Name: _____Provider Contact # (___)_____
Policy #: _____ Group #: _____
Policy Holder (if different than patient): _____ D.O.B:_____
Address (if different from above): _____

MEDICAL HISTORY:

Name of Primary Care Physician:_____ Phone: (___)_____
List of Allergies:_____
Do you: Smoke_____ or Drink_____ Frequency:_____

Please list all medication or vitamins, as well as dosage and frequency

Medication	Dosage	Frequency

Or, if you do not take any prescribed medication initial here: _____

Please list all hospitalizations, surgeries, major accidents or other past medical history

Type	Date	Reason

Or, if you do not have any past medical history initial here: _____

MEDICAL HISTORY-REVIEW OF SYSTEMS

Please LIST any and all medical problems that apply to you (past or present):

Describe any of the above: _____
If you deny all of the above and all other, initial here: _____

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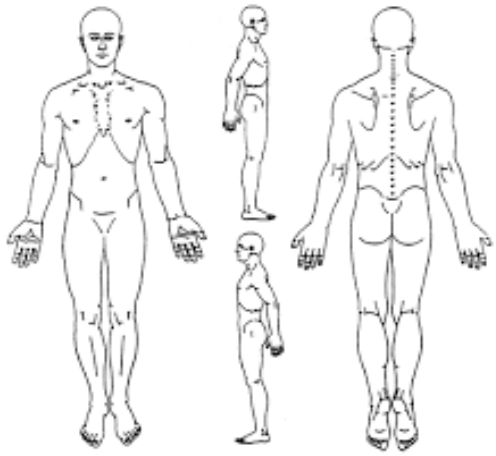
FEMALE ONLY:
Are you pregnant? Yes or No Date of Last Menstrual Cycle: _____

REASON FOR VISIT
What is your area(s) of complaint? :_____
When did this issue begin? _____Have you seen any other physicians?_____
If so, who? _____

Use the following symbols to describe your pain on the diagram:

^^^= Achy
///= Numbness/Pins & Needles
>>>= Stabbing
XXX= Burning
+++= Throbbing



How to you hear about our clinic?
_____
Is your pain (circle one): Getting better Staying the same Getting worse
Rate your pain from 0 (no pain) to 10 (worst pain): _____

INFORMED CONSENT

Please read this section in its entirety. Please ask questions before you sign if there is anything that is unclear.

Chiropractic Adjustment/Assessment/Analysis/Treatment
During the course of your treatment we may recommend and perform the following. Please circle ones in which you **DO NOT** consent to:

Spinal or extremity manipulation	Spinal and muscle palpation	Orthopedic testing	Postural analysis
Range of motion testing	Muscle testing	Ultrasound	Exercise therapy
Hot/Cold Pack	Neurological testing	Manual therapy	Nutritional

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			Supplementation

Availability of Other Treatment (May include, but not limited to):
-Over the counter medication -Rest
-Medical care (prescription medication) -Surgery

The Material Risks Inherent in Chiropractic Treatment

As with any healthcare procedure, there are certain complications associated. These complications include, but are not limited to: fracture, disc injuries, disclocation, muscle strain and burns. Some types of cervical manipulations have been associated with injuries to arteries to the neck leading to or contributing to complications including stroke. Stroke has been the subject of tremendous disagreement. The incidences of stroke are extremely rare and are estimated to occur one in million, to one in five million cervical manipulations. I will make every reasonable effort during my examination and review of your medical history to screen for contraindications to care, however, if you have a condition that would be otherwise not come to my attention, or fail to disclose in your intake, it is your responsibility to bring it to my attention.

I have read and fully understand the informed consent and material risks inherent in chiropractic treatment.

Patient Name:_____Date:_____
Guardian Name (if applicable):_____
Signature of patient or Guardian:_____

INNOVATIVE SPORTS MEDICINE HIPPA PRIVACY RECEIPT AKNOWLEGMENT

Innovative Sports Medicine has given me a copy of their Privacy Notice. By my signature, I acknowledge that I have received and understand how my protected health information will be handled.

PatientName:_____Date:_____
Guardian Name (if applicable):_____
Signature of patient or Guardian:_____

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INNOVATIVE SPORTS MEDICINE FINANCIAL POLICY

Please initial next to each number, indicating that you fully understand the financial policy. If you have questions, please ask before signing.

1. _____ (If applicable) Self-pay patients, payment is due at time of service
2. _____ I direct all payers to release to Innovative Sports Medicine (ISM) any pertinent information regarding any insurance coverage I may have. I authorize ISM to release any information regarding my treatment or pertinent information of my case to all payers without a copy of this consent.
3. _____ **Although we will make our best effort to verify your insurance benefits, you are responsible to know and understand your benefits. Quote of insurance coverage at the time of service does not guarantee coverage. Your insurance benefits are a contract between you and your insurance company.**
4. _____ You, or the guardian will be financially responsible for any and all outstanding charges that are not paid by insurance companies.
5. _____ **Any missed appointments without reasonable cancellation notice may be subject to a $25 no show fee.**
6. _____ If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.
7. _____ All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

I have read and understood the financial policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Guardian **Date**