IMPACT CHIRO SPORT
Chiropractic, Cryotherapy and Recovery Solutions

Please fill out the forms as completely and accurately as possible.

**Confidential Patient Information**

| | | |
|---|---|---|
| Name | | Date |
| Street Address | City/State | Zip Code |
| Home Phone ( ) | Work Phone ( ) | Cell Phone ( ) |
| Email Address | Date of Birth | Current Age |
| Cell Phone Carrier (for appointment reminders only) | Method of Payment (self-pay or insurance) | |

**Insurance Information if Applicable:**

| |
|---|
| Name of Insurance Company |
| Type of Plan ☐ Indemnity/Private ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ PI ☐ Other: |
| Billing Address |
| Policy Number |

**Referred by:**

| | | |
|---|---|---|
| ☐ Patient Name: | ☐ Physician Name: | ☐ Other: |

**Work Status**: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

| | | |
|---|---|---|
| Employer | Occupation | |
| Employer Address | City/State | Zip Code |

**Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widow Spouse's Name_____
**Children**: ☐ No ☐ Yes Children's Names _____ Age:____
_____ Age:____
_____ Age:____
_____ Age:____

**EMERGENCY CONTACT INFORMATION**

| | |
|---|---|
| Contact Name: | Relation: |
| Contact Phone: | Secondary Phone: |

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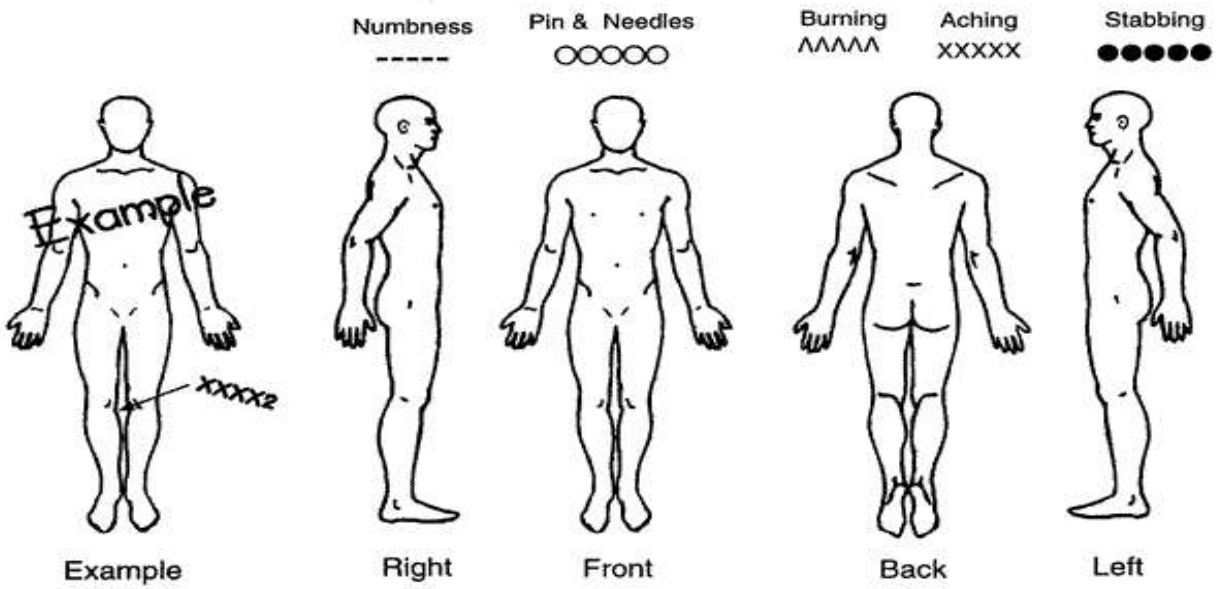
On the drawings below, please indicate where you are experiencing pain by using markings noted




***Complaint #1*** **(in order of severity)**

| |
|---|
| When did you first notice this condition: |
| Did it begin: ☐ Immediately or ☐ Gradually? Briefly describe |
| Where is the exact location of your symptoms: |
| Do your symptoms Spread? ☐ No ☐ Yes Where? |
| How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%) |
| Is this condition: ☐ Worsening ☐ Improving or ☐ Unchanged |
| Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) 1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐ |
| Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing |
| Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching If so, Please describe: |
| Please indicate what activities Provoke or Aggravate your condition: ☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold ☐ Coughing/sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright lights ☐ Other _____ ☐ Other_____ ☐ Other_____ ☐ Other_____ |

Please list what doctors you have seen for this condition. (Please include diagnoses, previous x-rays, treatment received, and any changes in your condition, if possible.)

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| |

Please include any other relevant history in regards to this complaint.

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|---|
| |

## *Complaint #2*

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|---|
| When did you first notice this condition: |
| Did it begin: ☐ Immediately or ☐ Gradually? Briefly describe |
| Where is the exact location of your symptoms: |
| Do your symptoms Spread? ☐ No ☐ Yes Where? |
| How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%) |
| Is this condition: ☐ Worsening ☐ Improving or ☐ Unchanged |
| Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) 1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐ |
| Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing |
| Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching<br>If Yes, please describe: |
| Please indicate what activities Provoke or Aggravate your condition:<br>☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold<br>☐ Coughing/sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright lights ☐ Other _____<br>☐ Other_____ ☐ Other_____ ☐ Other_____ |
| Please indicate what helps to alleviate the pain.<br>☐Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Meds _____<br>☐ _____ ☐ _____ ☐ _____ |

Please list what doctors you have seen for this condition. (Please include diagnoses, previous x-rays, treatment received, and any changes in your condition.)

| |
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| |

Please include any other relevant history in regards to this complaint.

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## *Complaint #3*

| |
|---|
| When did you first notice this condition: |
| Did it begin: ☐ Immediately or ☐ Gradually? Briefly describe |
| Where is the exact location of your symptoms: |
| Do your symptoms Spread? ☐ No ☐ Yes Where? |

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How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)

Is this condition: ☐ Worsening ☐ Improving or ☐ Unchanged

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)
1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching
If Yes, Please describe:

Please indicate what activities Provoke or Aggravate your condition:
☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold
☐ Coughing/sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright lights ☐ Other _____
☐ Other_____ ☐ Other_____ ☐ Other_____

Please indicate what helps to alleviate the pain.
☐Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Meds _____
☐ _____ ☐ _____ ☐ _____

Please list what doctors you have seen for this condition. (Please include diagnoses, previous x-rays, treatment received, and any changes in your condition.)

Please include any other relevant history in regards to this complaint.

## *Additional Complaints*

Please list any additional complaints in the area below.

## Past Medical History

**Please list any previous injuries, dates and treatment received** (i.e. sprained ankles, severe cramping, falls, etc.)

Did/Do you have any abnormal neurological, structural or developmental conditions? ☐ No ☐ Yes If No, Please Explain:

Illnesses/Hospitalizations: ☐ No ☐Yes Explain:

Injuries, Accidents, Falls, or Traumas ☐ No ☐Yes Explain:

Surgeries: ☐ No ☐Yes Explain:_____

***Females Only:*** What age did you start your menses? _____ ☐ Regular ☐ Irregular Menopause? ☐ No ☐Yes
Have You Taken or Are You Currently Taking Birth Control Pills? ☐ No ☐Yes For How long?

**Medications, Vitamins, Minerals, and Supplements** Please list your current.

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# FINANCIAL POLICY

We strive to provide you with excellent care in a clean, friendly, professional setting and our goal is to make each visit as convenient as possible. By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any changes to contact information.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no later than 12 hours prior to your scheduled time so that we may offer that time to another patient. Failure to give proper notice of cancellations may result in a $25.00 "Missed Appointment Fee".
- A returned check will result in a $35.00 service charge.

**IF YOU HAVE HEALTH INSURANCE COVERAGE:** As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic and Physical Therapy care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance or any other health/medical plan, to issue payment check(s) directly to Impact ChiroSport for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. By Signing Below you acknowledge the following:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

We realize that temporary financial problems arise from time to time. If you're faced with such hardship, we urge that you contact us for assistance in the management of your account to discuss options we may have. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP!** By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

| Print | Sign | Date |
|---|---|---|

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## CONSENT TO RELEASE INFORMATION

Impact ChiroSport is committed to maintaining patient confidentially. Our policy is to speak only to patients and/or guardians personally in regards to their confidential information. By signing below, you acknowledge that our providers/staff be allowed to communicate information to insurance carriers and/or other parties processing your claim. You also consent to allow Impact ChiroSport to send reminders regarding your appointments by either email and/or text listed in the file unless otherwise noted. ***This form will be effective until otherwise notified by the patient with a written request.***

**CONSENT TO RELEASE INFORMATION TO AN ADDITIONAL PARTY/INDIVIDUAL:** I hereby give my consent for Impact ChiroSport to release my medical records to the following additional party/individual:

☐ None Additional. ☐ Release to: _____

**Patient Consent for Photograph Use:** Photographs may be taken ONLY with your permission while being treated or having any other services provided. These photos may be used on our website, social media and/or other means. I give consent to Impact ChiroSport to use such photographs of me or my child (or person for whom I am legal guardian). I understand the image may be seen by members of the general public that visit the clinic, website, or social media posted by Impact ChiroSport. Although these photographs may be used without identifying information such as name, I understand that it is possible that someone may recognize me. By consenting to these photographs, I understand that I will not receive payment from any party.

By signing below I acknowledge and accept the above Consents and terms outlined. If there is a section that you do not wish to consent to, please mark an "X" through that section and please write your initials next to the applicable section and proceed by signing below pertaining to the remaining Consents:

_____ _____ _____
Print Sign Date

# Department of State Health Services Notice of Privacy Practices

## ACKNOWLEDGEMENT OF REVIEW

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective September 1, 2017), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____ _____
Print Sign Date

If completed by a patient's personal representative or legal guardian, please print and sign your name in the space below.

_____ _____ _____
Print Sign Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained due to:

___ Individual refused to sign.
___ Communication barriers prohibited obtaining the acknowledgement
___ Emergency situation prevented us from obtaining acknowledgement
___ Other: _____

***The Nature of Chiropractic Treatment offered by Dr. Joshua C. Edwards, B.S., D.C.***

Chiropractic treatment consists of evaluating, diagnosing and treating the conditions warranted through the means of using hands, mechanical instruments, various modalities as well as the use and instruction of exercise and/or stretching. When manipulations are performed, you may feel joint movement and you may hear joints "click" or other sounds. Some patients will feel some soreness and/or stiffness following the first few days of treatment. These are normal and not a cause for concern.

# *Informed Consent for Chiropractic Care*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and modalities, on me (or on the patient named below, for whom I am legally responsible for) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or any staff members of Impact ChiroSport.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Relative Contraindications: Adds significant risk of injury to the patient but does not rule out the use of dynamic thrust. These conditions include: articular hypermobility, severe bone demineralization, benign bone tumors, bleeding disorders, anticoagulant therapy, progressive radiculopathy (meaning weakness, muscle loss, bowel/bladder symptoms).

Absolute Contraindications: Manipulation (including low force techniques) is absolutely contraindicated when the following are present: acute arthropathy, acute/unstable fractures, unstable dens, malignancy of the spine/involved region, infection of the spine, myelopathy, VBS in the cervical spine, arterial aneurysm in the area.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

| _____ | _____ | _____ |
|---|---|---|
| Print | Sign | Date |

## Consent to Treat a Minor (if applicable)

I hereby authorize Dr. Joshua C. Edwards and whomever he may designate to perform chiropractic care and other treatment to my MINOR CHILD, _____, date of birth _____. I also give Impact ChiroSport the right to perform these same services on my child without a parent or legal guardian being present. As of this date, I have the legal right to select and authorize health care service for the minor named above and I agree to the Informed Consent noted above. (If applicable) Under the terms and conditions of a divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to authorize this care be revoked or modified, I will immediately notify this office.

| _____ | _____ | _____ |
|---|---|---|
| Print | Sign | Date |