Longview Spine & Sports Medicine

Patient Name:_____ Date: _____ DOB: _____
SS#/SIN:_____ Email:_____ □ Male □ Female
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Check Appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated
Patient's Address/City/State/Zip: _____
Employer Name: _____
Spouse or Patient's Guardian Name: _____Spouse's Employer: _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency: _____ Phone: _____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

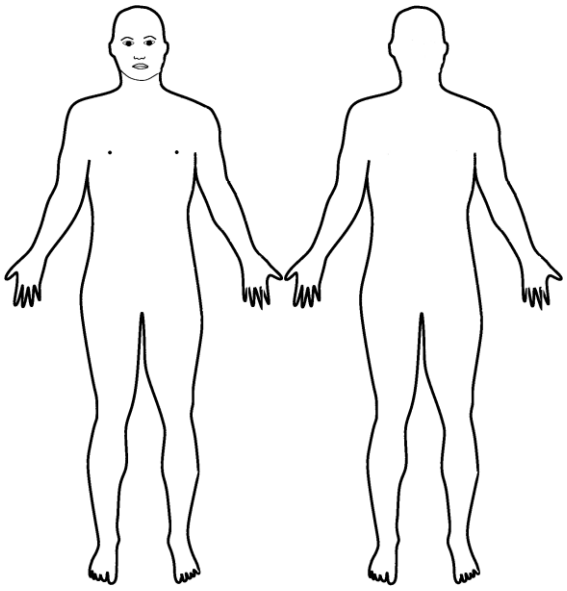
_____
Parent or Guardian Signature Date

Responsible Party
Name of The Person responsible for this account _____
Relationship to Patient: _____ Address: _____
Home Phone _____ Cell Phone _____Email:_____
Driver's License # _____ DOB:_____ Is the person currently a patient at our office?
□ Yes □ No

Do you have any Medical insurance?
□ Yes □ No If yes, complete the following:
Name of the Insured_____
Relationship to Patient:_____ DOB:_____ SS#/SIN:_____
Name of Employer: _____ Work Phone _____
Employer Address/State/Zip:_____
Insurance Company_____ Union or Local # _____
Member ID: _____ Group # _____
Ins. Co. Address/City/State/Zip: _____
_____ *Initial* **- I understand that by allowing Longview Spine and Sports Medicine to file insurance claims on my behalf, it is not a guarantee of payment and that ultimately the outstanding balance is my responsibility.**

WHERE DO YOU HURT?
PLEASE CIRCLE
HISTORY OF PRESENT ILLNESS:

1. Where are you having pain today?
   _____
2. Please circle your symptoms:
   Radiating Sharp Stabbing Tightness
   Numb Dull Tingling Shooting
3. What is the intensity of your symptoms:
   None Minimal Mild Moderate Seve
4. On a scale from 1-10, with 1 being MILD, 5 being MODERATE, and 10 being SEVERE, circle the number that best describes how you feel: 1 2 3 4 5 6 7 8 9 10



Longview Spine & Sports Medicine

HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO YES	Asthma	NO YES
Anemia	NO YES	Smallpox	NO YES
Back Trouble	NO YES	Cancer	NO YES
Hepatitis	NO YES	Hives of Eczema	NO YES
Mumps	NO YES	Pneumonia	NO YES
Bladder Infection	NO YES	Polio	NO YES
High Blood Pressure	NO YES	AIDS & HIV	NO YES
Ulcer	NO YES	Rheumatic Fever	NO YES
Chicken Pox	NO YES	Glaucoma	NO YES
Epilepsy	NO YES	Infectious Mono	NO YES
Low Blood Pressure	NO YES	Arthritis	NO YES
Kidney Disease	NO YES	Hernia	NO YES
Whooping Cough	NO YES	Bronchitis	NO YES
Migraine Headaches	NO YES	Venereal Disease	NO YES
Hemorrhoids	NO YES	Blood or Plasma Transfusion	NO YES
Thyroid Disease	NO YES	Mitral Valve Prolapses	NO YES
Scarlet Fever	NO YES	Stroke	NO YES
Tuberculosis	NO YES	Any Other Disease	NO YES
Bleeding Tendency	NO YES	(Please List):_____	
Diphtheria	NO YES	_____	
Diabetes	NO YES		

PATIENT SOCIAL HISTORY:

Marital Status Single:_____ Married:_____ Divorced:_____ Widowed:_____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily:_____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily:_____

Use of Drugs Never: _____ Type/Frequency:_____

Excessive Exposure at home or at work to:

Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

HOSPITALIZATIONS/SURGERIES	WHEN?	HOSPITAL/CITY/STATE

MEDICATION: (Include Nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for Acid Indigestion

‿ YES ‿ NO If yes what type:

_____

LIST ALLERGIES/MEDICATION ALLERGIES:

_____

Longview Spine & Sports Medicine

FAMILY MEDICAL HISTORY:

	Age	Disease	If Deceased, Cause Of Death
Father:			
Mother:			
Siblings:			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**		**Neurological**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Tingling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5		
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	**General**	
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Fatigue	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Malaise	1 2 3 4 5
Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5	Weakness	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5	Tiredness	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Constipation	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Shoulder Blade Pain	1 2 3 4 5	Diarrhea	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian **Date**

Doctor's Review

_____ _____

Signature of Doctor **Date**

Authorization for Release of Information to Family Members and Healthcare Providers

Many of our patients allow family members such as their spouse, parents, healthcare providers or others to call and request medical or billing information. Under the Requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Longview Spine & Sports Medicine to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____ Date: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am **ultimately responsible to pay Longview Spine & Sports Medicine as well as David Buller M.D., Shania McBride FNP, Randy V. Curtis D.C**., **Lance Potter D.C**.,(hereinafter collectively referred to as "Health Care Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Health Care Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Health Care Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Health Care Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Health Care Provider, myself, and/or my family members as a result of services rendered by Health Care Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Health Care Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Health Care Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Health Care Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____. X_____(SEAL)
(Patient Signature)

X_____(SEAL) X_____
(Signature of Guardian if Applicable) **(Print Patient Name)**

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) 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 office listed below. I have had an opportunity to discuss with the Doctor of Chiropractic named below 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 and diagnostic services including but not limited to:
Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains. Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions. Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.
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. The doctor named below has additionally explained the risks associated with my refusal of treatment. 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.

Patient/Guardian Signature:_____ Date: _____
Witness Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT
ACKNOWLEDGEMENT FORM
(ASK FRONT DESK FOR COPY)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____Birthdate: _____ Date: _____
Signature:_____

EXPLANATION OF BENEFITS

I understand that every attempt will be made to provide complete and accurate insurance information coverage. However, final insurance payment coverage is not determined until a claim is processed by my insurance and an Explanation of Benefits is provided to myself and Longview Spine and Sports Medicine. All financial payment plans discussed prior to my claims being submitted are understood to be an estimate and all remaining balances unpaid by my insurance is my responsibility.

Signature: _____ Date: _____