THE MOVEMENT CLINIC

Patient Information

Name _____

Address _____

_____

Phone _____

Email _____

Date of Birth _____

Social Security # _____

☐ Female ☐ Gender Male

Height _____Weight _____

Marital Status_____

Spouse Name _____

Number of Children _____

Emergency Contact Information:

Name _____

Phone_____

Relation _____

Current Health

Other than the reason for your visit, do you have any additional health concerns involving any of the following? (if so, explain)

Muscles, bones, or joints
☐ No ☐ Yes
_____

Nerves, headaches, dizziness, or emotional
☐ No ☐ Yes
_____

Head, eyes, ears, nose, throat
☐ No ☐ Yes
_____

Heart, blood pressure, or circulation
☐ No ☐ Yes
_____

Shortness of breath, coughing, asthma or lung condition
☐ No ☐ Yes
_____

Stomach, bowels, digestive conditions
☐ No ☐ Yes
_____

Genital, bladder, urinary conditions
☐ No ☐ Yes
_____

Diabetes, thyroid, or glandular conditions
☐ No ☐ Yes
_____

Skin or bleeding conditions
☐ No ☐ Yes
_____

Allergies or sensitivities
☐ No ☐ Yes
_____

Reason for Visit

On a scale of 1 to 10, with 10 being most serve, how would you rate your current level of

THE MOVEMENT CLINIC

Appointment Date _____

How long have you had this complaint?
- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

Cause of condition, if known:

_____

Date condition began _____

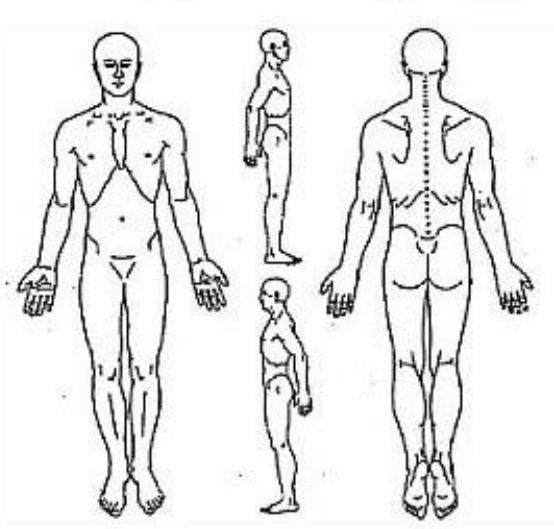
Terms which best describe your discomfort (aching, burning, tingling, etc.)

_____

_____

On the body diagram, please indicate your areas of symptoms by drawing in the appropriate symbols.

P- Pain **N**- Numbness **W**- Weakness
S- Shooting **A**- Aching



discomfort?

1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort?
- ☐ Constant
- ☐ Frequent
- ☐ Occasional
- ☐ Intermittent

How has this complaint changed since the onset?
- ☐ Worsened
- ☐ Remained the same
- ☐ Improved

What activity is the most significantly affected by this discomfort? (Explain)

_____

_____

What treatment have you received for this condition up to now?

_____

_____

Have you had any surgical procedures? (If so explain)

_____

Are there any past illnesses or family conditions we should be aware of?

_____

_____

Are you presently taking medication? (Explain)

_____

THE MOVEMENT CLINIC

Work and Social Habits

Current work habits (select all that apply)
- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired
- ☐ Student
- ☐ Homemaker
- ☐ Unemployed

Personal social habits (select all that apply)
- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits (select all that apply)
- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits (select all that apply)
- ☐ Vegan
- ☐ Vegetarian
- ☐ Daily supplements
- ☐ Other

Referral Information

Referring Physician

_____

Referring Patient

_____

Are you working with an attorney?

☐ No ☐ Yes

How did you hear about us?

- ☐ Word of Mouth
- ☐ Advertisement
- ☐ Social Media
- ☐ Direct Marketing
- ☐ Internet

THE MOVEMENT CLINIC

Informed Consent to Treatment

I certify that I'm the patient or legal guardian listed above. I have read/understand included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorized this office and its staff to examine and treat my condition as the doctor see fit. I hereby authorized the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant authorization with my signature for required insurances submission. I understand and agree that all services rendered to me will be charged to me and I'm responsible for timely payment of such services. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature _____

Date _____

Patient Election to Self- Pay

This office may participate in my personal health insurance plan, if any, and I understand certain health plans may require submission of claims for consideration of payment. I understand my health plan, if any, may include benefits from some or all of the services that are proposed by this office.

I also herby elect to self-pay for services rendered to me at this office. By electing to self-pay for certain designated services, any payments made to this office will not be billed to my health plan, if any, and/or credited towards any deductible or coinsurance obligation under my health plan unless allowed by that plan.

Unless requested in writing, I hereby direct this office to not submit claims for specific services in which I elect to self-pay. Such information may include but not be limited to my diagnosis, history, payments, office notes and/or other documentation necessary for traditional third-party insurance payment.

I understand I am fully responsible for services accrued at this office. I acknowledge I may qualify for other discounts offered through this office, including but not limited to a Patient Options discount medical plan organization membership fee schedule on file with this office.

Signature: _____

Name: _____

Date: _____

Patient Options Access Program

Free Patient Enrollment Agreement

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This agreement and its terms and conditions, is between you and Patient Options. This agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your provider and shall continue for a period of exactly one year(12months) from the date of signature below. You will automatically be re-enrolled for successive one-year periods unless requested in writing.

There are no fees, dues, charges, or other consideration required for participation.

Disclosures:

- The program provides discounts to you from contracted healthcare providers for services rendered;
- The program participant is obligated to pay for all healthcare services directly to provider but will receive a discount from healthcare providers who have contracted with Patient Options;
- This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where a third-party insurance company is responsible for charges.
- Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this agreement
- The name and address of the Discount Managed Care organization is: Patient Options;9435 Waterstone Blvd, Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient options.

I have read and agree to the terms and conditions set forth above:

Name: _____

Signature: _____

Date: _____

Address: _____

Additional Household participants may be enrolled under the same terms of this agreement. To activate please write their names below:

1. _____

THE MOVEMENT CLINIC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUI ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provide, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider al of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, Insurance or applicable legal or administrative remedies (Including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERICSA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

Name: _____

Signature: _____

Date: _____

As a courtesy to our patients, we do our best to notify you of your benefits, however, it is the patients responsibility to know if your insurance has any deductible, co-payment, co-insurance, out-of-network, visit limit, prior authorization requirements or any other type of benefit limitation for the services you receive.

I have read and understand the terms stated above:

Name: _____

Signature: _____

Date: _____