BACK & BODY MEDICAL CENTER, LLC

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

***Please present ALL Insurance cards and Drivers License to the receptionist**

ALL FIELDS ARE REQUIRED TO BE COMPLETED.

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)_____ (MI)_____ (Last)_____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Divorced Widow

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security#: _____

Home Phone: _____ Cell: _____ Email address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

Referring Physician: _____ Town: _____ Phone#:_____

Primary Care Physician: _____ Town: _____ Phone#:_____

Emergency Contact Name: _____ Relationship: _____Phone#:_____

New Patients: How did you hear about us? Family Friend Physician Self Referred ER
Newspaper/ Magazine Brochure Internet TV Radio Other

Primary Insurance Plan:_____ID#_____

Address: _____

Primary Insurance Plan Holder's Name:_____ DOB:_____ Relationship to patient:_____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder: _____

Secondary Insurance Plan: _____ID#_____

Address: _____

Secondary Insurance Plan Holder's Name:_____ DOB:_____ Relationship to patient:_____

Patient Release: MUST BE SIGNED BY PATIENT : I hereby authorize Back & Body Medical Center, LLC to disclose to my insurance company(s) copies of my medical record(s) to obtain payment for services or as part of payment review of medical services, *or in the case of Workers Compensation Motor Vehicle claims, to my present or past employer(s)*. I understand that I am financially responsible for all charges if they are covered by insurance. I also understand that I will be balance billed for any amount not covered by insurance. I authorize Back & Body Medical Center, LLC to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment I recognize that the information disclosed may be protected by federal and/ or state law, and I specifically consent to disclose such information.

Patient Signature: _____ **Date:** _____

BACK & BODY MEDICAL CENTER, LLC

Patient Medical History and Chief Complaint

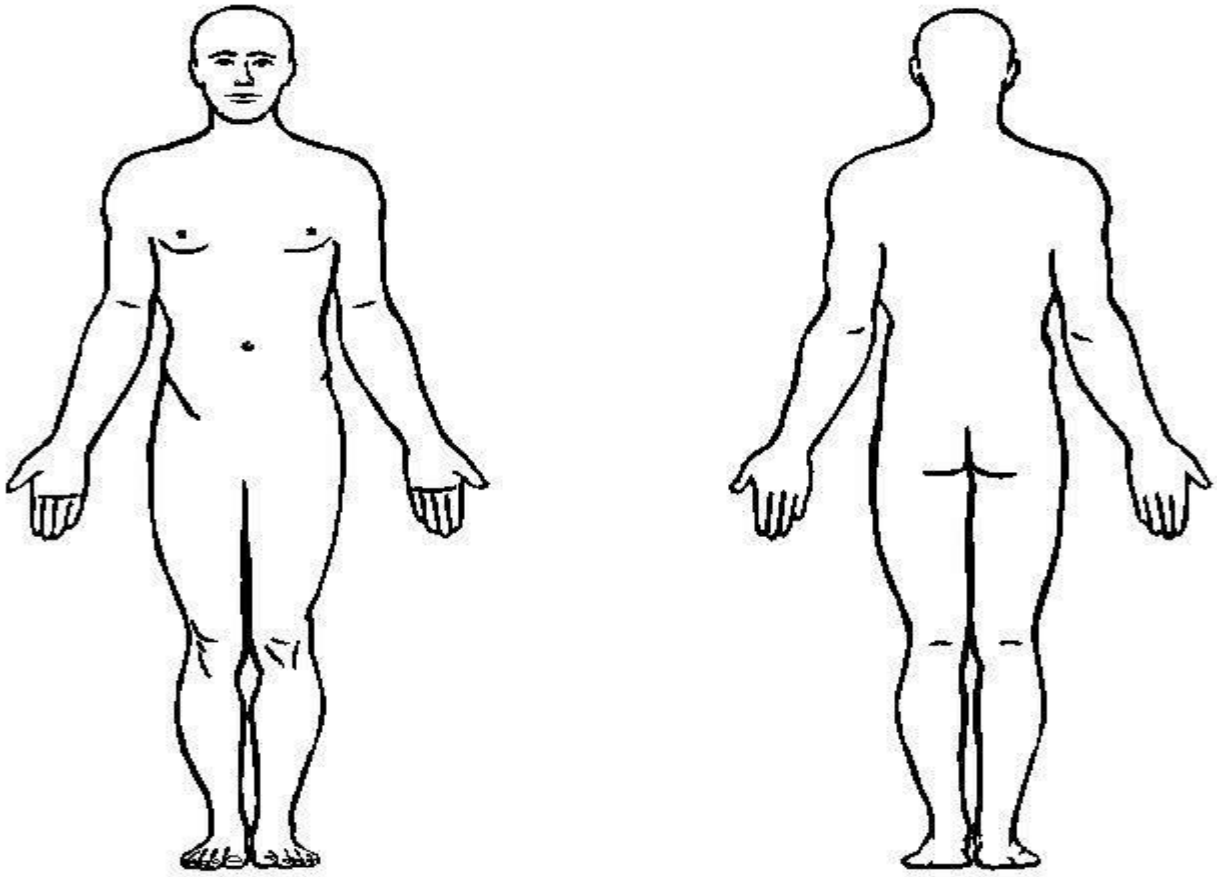
Please describe the reason(s) for your visit today: _____

_____

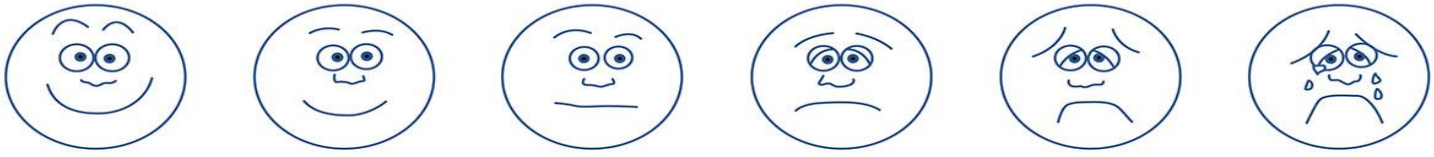
_____

Pain Diagram

- Please shade in effective areas
- LABEL type of sensation or pain in each area (example: burning, aching, throbbing, stabbing, tingling, numbness etc.)
- If multiple locations please indicate where pain is most severe.



Wong-Baker FACES® Pain Rating Scale



BACK & BODY MEDICAL CENTER, LLC

Past Medical History

Surgeries (include dates) _____

_____

Allergies to medication or foods (please list) _____

Please mark your past medical history (illnesses/ injuries/ hospitalizations etc.)

○ Anemia ○ Headaches ○ Head Injury/Concussion ○ Osteoporosis ○ Arthritis ○ Thyroid Problems
○ Seizures ○ Blood Clots ○ Asthma/ Lung Disease ○ Cancer ○ Stroke ○ Kidney Disease
○ Hypertension ○ Diabetes ○ Heart Disease
○ Other _____

Please list your history of motor vehicle accidents, back injuries, etc. (date/ did symptoms resolve/ duration of symptoms)

_____

_____

Review of Systems

Please circle all that apply to your current state of health

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nail changes
Head/Neck	Head injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks/ Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardio-vascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of conscious-ness		
Gastro-Intestinal	Abdominal pain	Nausea/vomiting	Diarrhea/ Constipation	Bright red Blood per rectum	Dark, black Tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount) _____	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness/Tingling	Bowel/ Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip Pain	Knee Pain	Shoulder Pain	Back Pain	Joint Pain	

BACK & BODY MEDICAL CENTER, LLC

Social History:				
	Never*	**Occasionally**	**Frequently**	**Daily**
Alcohol Use				
Tobacco (Specify:_____)				
Cigars				
Illicit Drugs (Specify:_____)				
Vape				

*If you have quit indicate when

Conservative Treatment prior to Office Visit today			
	Was it successful	**Did you only get temporary relief**	**Comments (Last Visit/Intervention)**
Physical Therapy			
Bed Rest			
Cervical Collar			
Pain Medication			
Chiropractor Name: _____			
Epidural Steroid Injection			
Pain Management Doc: _____			

Family History: Check if applicable and relationship:				
	Mother	**Father**	**Sister**	**Brother**
Cancer				
Diabetes				
Epilepsy				
Tuberculosis				
Stroke				
Aneurysm				
Sudden Death/ Brain Bleed				
High Blood Pressure				

Medication List

Medication Name	Dosage (mg)	Frequency	Date Started	Date Discontinued

BACK & BODY MEDICAL CENTER, LLC

HIPAA Notice and Information

Patient Name: _____ **DOB:** _____

Our intent of this notice is to make you aware of Back & Body Medical Center's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996. The Notice of Privacy Practices outlines possible uses and disclosure of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement.

I acknowledge and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

If you decline to provide a signed acknowledgement, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment and healthcare operations when necessary.

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Back & Body Medical Center from discussing appointments, medications, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Name of Individual (please print)	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Date:** _____

BACK & BODY MEDICAL CENTER, LLC

Permission for Billing office to file complaint/ grievance/ appeal on patient's behalf for payment

To Whom It May Concern:

I authorize Back & Body Medical Center to act as my representative in connection with complaint / grievance/

appeal with (insurance company)_____.

I authorize this group to make any request to present or elicit evidence; to obtain information and to receive any notice in connection with my complaint/ grievance or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of complaint/ grievance or appeal.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand this information and grant my consent for my representative to file a complaint/ grievance or appeal on my behalf.

Thank you.

Date: _____

Patient Name: (print) _____

Patient Signature: _____

Date of Birth: _____

BACK & BODY MEDICAL CENTER, LLC

Medicare Signature on File

Please complete this form in order to ensure proper billing of your services;
Skip if you are not insured by Medicare or a Medicare Replacement plan

I request the payment of authorized Medical Benefits be made on my behalf to Back & Body Medical Center for any services furnished to me by the listing provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the provider of service.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "Other health insurance" is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information other insurer or agency shown.

Back & Body Medical Center agrees to accept the charge determination of the Medicare Carrier as the full charge**, I am responsible for and deductible and/or co-insurance deemed payable by Medicare.**

Medigap (Medicare Secondary Insurance)

I request that payment of the authorized Medigap benefits be made either to me or on my behalf to Back & Body Medical Center for any services furnished to me by that Physician. I authorize information about me to release Medigap Coverage needed to determine benefits payable for related services.

Patient Name: _____

Patient Signature: _____ **Date:** _____