SPINE AND SPORTS INJURY CENTER

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This history will be part of your permanent records. THANK YOU!

Name: _____ Date of Birth: _____ Gender: M F other: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Marital Status: M D S W Children, Ages: _____ Spouse Name: _____

Insurance Company: _____ Policy ID#: _____

Occupation: _____ Employer: _____

Who referred you to us? _____ How else did you hear about us? _____

What is your primary complaint? _____ For how long? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ⚪ Improved ⚪ Unchanged ⚪ Getting Worse

Is this condition interfering with: ⚪ Work ⚪ Sleep ⚪ Daily Routine ⚪ Other: _____

Has THIS condition been treated? _____ OTHER conditions? _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

Medications, dosage, and frequency: _____

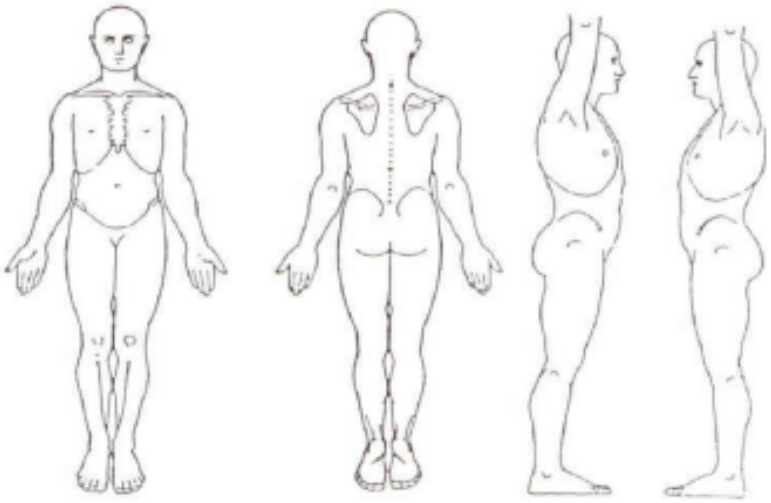
_____

Have you been into an auto accident or had any other personal injury? ⚪ Y ⚪ N

If yes, please describe: _____

Please rate this pain severity 0 - 10. 0 = no pain, 10 = emergency room pain. Please locate your symptoms.

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10



XX = Pain

TT = Tight

OO = Tingling / Burning / Numb

Medical History:
Please mark if you have ever had…

- ⚪ Arthritis
- ⚪ Anemia
- ⚪ Nausea / vomiting
- ⚪ Headaches
- ⚪ Dizziness / vertigo
- ⚪ Head Injury
- ⚪ Anxiety
- ⚪ Depression
- ⚪ Hearing Loss
- ⚪ Hernia
- ⚪ Fatigue / Weakness
- ⚪ Fibromyalia
- ⚪ Seizures / Epilepsy
- ⚪ Thyroid Problems
- ⚪ Diabetes
- ⚪ Asthma
- ⚪ Heart Disease
- ⚪ High Blood Pressure
- ⚪ Other: _____

Exercise Habits (gym, outdoors, walk to work etc):_____

_____

Past Injuries (fractures, sprains, strains, other painful conditions): _____

_____

Current weight: _____ Have you recently lost or gained weight? _____

Mental work:	⚪ Heavy	⚪ Moderate	⚪ Light	_____Hours daily
Physical work:	⚪ Heavy	⚪ Moderate	⚪ Light	_____Hours daily
Exercise:	⚪ Heavy	⚪ Moderate	⚪ Light	_____Hours daily

Do you smoke? ⚪ Y ⚪ N

- Packs / Day: _____ # of years: _____

Do you drink alcohol? (wine, beer, liquor) ⚪ Y ⚪ N

- Drinks/ Week: _____ # of years: _____

Do you drink caffeine? (coffee, tea, sodas, energy drinks):

- Cups / Day: _____

Are you taking blood thinners? ⚪ Y ⚪ N

Are you or is there a chance you could be pregnant? ⚪ Y ⚪ N

Are you aware of any problems or have any concerns with your immune system? ⚪ Y ⚪ N

Do you have any known disease or infection that can be transmitted through bodily fluids? ⚪ Y ⚪ N

Do you have a pacemaker or any other electrical implants? ⚪ Y ⚪ N

Are you currently taking antibiotics for an infection? ⚪ Y ⚪ N

Are you diabetic or suffer from impaired wound healing or peripheral neuropathy? ⚪ Y ⚪ N

Do you have HIV, Hepatitis B, Hepatitis C or any other infectious disease? ⚪ Y ⚪ N

PHYSICIAN'S INFORMATION

Primary Care Physician: _____Affiliation: _____

Phone: _____ Fax: _____

Referring Physician: _____Affiliation: _____

Phone: _____ Fax: _____

By signing, you consent to sharing your initial examination notes with the physicians listed above.

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INFORMED CONSENT FOR EXAMINATION, TREATMENT, AND USE OF HEALTH INFORMATION

I (we) consent to the examination and treatment by the licensed Doctor of Chiropractic and/or licensed physical therapists at Spine and Sports Injury Center. I understand that treatment is not an exact science and may involve clinical judgment based on known facts. While the goal is to provide the best care possible, I acknowledge that no treatment guarantees a specific result, and I consent to the inherent risks of chiropractic and physical therapy care, including, but not limited to, fractures, disc injuries, strokes, and sprains/strains.

I have had the opportunity to discuss the nature, purpose, and potential risks of my treatment with the doctor(s) or clinic personnel, and I have had the chance to ask questions. I understand that this consent applies to both current and future treatment for any conditions I may seek care for.

I also consent to Spine & Sports Injury Center's use and disclosure of my protected health information for treatment, payment, and healthcare operations as outlined in the clinic's **Notice of Privacy Practices**. I understand that I have the right to review and request restrictions on how my information is used, but that such requests may not always be granted. I may revoke this consent in writing at any time, except for information already disclosed.

HEALTH INSURANCE POLICIES AND PROCEDURES

Accepted Insurances

For Chiropractic Treatment, we are in network with Aetna, Blue Cross Blue Shield, Harvard Pilgrim Healthcare, and Health Plans Inc., Wellpoint (formerly Unicare), and Mass General Brigham Health Plan.

For Physical Therapy Treatment, we are in network with the same as Chiropractic, as well as United Healthcare/Harvard Pilgrim (also known as Passport Connect), Tufts, and Medicare.

Additionally, we accept Workers Compensation, and Motor Vehicle Accidents for both Chiropractic and Physical Therapy. Our office is happy to check your coverage for you; however,you are ultimately responsible for knowing your benefits.

Copays/Coinsurances/Deductibles

Our billing office will be happy to process your visit claims through your health insurance company for reimbursement. After your health insurance pays their portion, you will be responsible for the balance. If you have any questions about your insurance plan as it relates to your coverage for Chiropractic or Physical Therapy Treatment, please contact your insurance carrier for further explanation.

Insurance Disclaimer

Please be aware insurance is subject to change at any time. You are responsible for any changes that occur during your treatment, and you will be billed for any left over after your insurance has paid Spine and Sports Injury Center.

SELF PAY POLICIES AND PROCEDURES

For patients without insurance, for those whose insurance we do not accept, and for any services not covered by insurance, the following rates apply:

- **Initial Evaluation (Chiropractic & Physical Therapy):** $195.00
- **Follow-Up Visits:**
  - Chiropractic (20 minutes): $125.00
  - Physical Therapy (40 minutes): $145.00
- **Dry Needling:**
  - As an additional service, not covered by insurance: $25 per session
- **Dry Needling Only:**
  - Initial Visit: $195
  - 30 min Follow-Up Visits: $110 per session
- **Class IV Laser Only:**
  - Initial Visit: $195
  - Follow-Up Visits: $75 per session
- **ARP Wave Only:**
  - Initial Visit: $195
  - 30 min Follow-Up Visits: $120

Any additional services outside the standard treatment plan may result in extra charges. These fees will be discussed and agreed upon before treatment begins.

Payment is due at the time of service. We accept cash, credit cards, and HSA/FSA payments.

CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give us 24-hour notice (call Friday for Monday appointments).

If you miss a scheduled appointment or if you cancel within 24 hours, a **$97 missed appointment fee** will be charged to your account. **Insurance companies will not pay for missed appointments.**

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DRY NEEDLING

Description:

Dry Needling (DN) involves inserting a tiny monofilament needle into symptomatic tissue with the intent to reduce pain, increase circulation and improve function of the neuromusculoskeletal system. DN is not traditional Chinese Acupuncture, but instead is based on neurology, physiology and western medical principles. DN is a valuable treatment for musculoskeletal pain; however, like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the Procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and/or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely.

Financial Responsibility and Insurance Disclaimer:

I understand that dry needling is considered an elective treatment and is not covered by insurance. As such, I acknowledge that I am fully responsible for the cost of each dry needling session. The fee for this service is **$25 per treatment session**, payable at the time of service.

I agree that I will not submit claims for dry needling treatment to my insurance provider for reimbursement, nor will I hold the treating provider or clinic responsible for any denied insurance claims related to this service.

VIDEO AND MEDIA RELEASE

I hereby grant **Spine & Sports Injury Center** and its representatives permission to record video and/or take photographs of me during my treatment, therapy sessions, or related activities. I understand that these recordings may be used for educational, marketing, and promotional purposes on the clinic's **social media platforms**, including but not limited to:

- **Instagram**
- **Facebook**
- **YouTube**
- **Website & Other Promotional Materials**

I acknowledge that:

1. My participation is voluntary, and I am not entitled to any compensation.
2. The videos/photos may be edited, copied, published, or distributed without additional approval from me.
3. I may withdraw my consent at any time by providing written notice to **Spine & Sports Injury Center**. However, I understand that previously shared content cannot be removed from online platforms.

I release **Spine & Sports Injury Center**, its employees, and affiliates from any claims or liability related to the use of my image, likeness, or voice in the recorded content.

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CREDIT CARD PAYMENT AUTHORIZATION

By signing this form, you give us permission to debit your account for your contractual copayment, coinsurance, or deductible agreement set by your insurance provider, as well as any additional fees associated with elective treatments not covered by insurance. This authorization will go into effect on the date of your first office visit. This is permission for repeated transactions only after confirmed office visits and does not provide authorization for any additional unrelated debits or credits to your account. **Our office will notify you before any payments outside of your normal copayments are due, and we will gain your verbal authorization before processing these payments.** You have the right to itemized receipts furnished upon your request by one of the methods below. This authorization becomes void when verbal, electronic, or written confirmation has been made to the office to discontinue electronic debits.

I, _____, authorize Spine and Sports Injury Center to charge my credit card account indicated below for any copayment, coinsurance, deductible, and other treatment related services as applicable.

Billing Address: _____ Phone: _____

City, State, Zip: _____ E-mail: _____

Account Type: Visa Mastercard Amex Discover HSA/ Flex Account

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CVV: _____

I authorize Spine and Sports Injury Center to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods / services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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PATIENT ACKNOWLEDGEMENT AND CONSENT

Please initial next to each section to indicate that you have read, understand, and agree to the terms outlined. By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in this **New Patient Intake Form**, including but not limited to the following sections:

_____ **Informed Consent for Examination, Treatment, and Use of Health Information**
I consent to chiropractic and/or physical therapy treatment at Spine & Sports Injury Center and understand the potential risks involved. I also consent to the use and disclosure of my protected health information as outlined in the clinic's **Notice of Privacy Practices**.

_____ **Health Insurance Policies and Procedures**
I understand my financial responsibility regarding my insurance coverage, including copayments, deductibles, and policy changes.

_____ **Self-Pay Policies and Procedures**
I acknowledge my financial responsibility for services not covered by insurance.

_____ **Cancellation Policy**
I understand that if I fail to provide at least 24 hours' notice for a cancellation, I will be charged a $97 missed appointment fee, which is not covered by insurance.

_____ **Dry Needling Consent and Financial Responsibility**
I consent to dry needling treatment and acknowledge that it is an elective procedure not covered by insurance. I accept full financial responsibility for the $25 per session fee.

_____ **Video and Media Release**
I grant permission for Spine & Sports Injury Center to record, photograph, and use my likeness for educational and promotional purposes. I understand that I may withdraw consent in writing, but previously shared content cannot be removed.

_____ **Credit Card Payment Authorization**
I authorize Spine & Sports Injury Center to charge my credit card for contractual copayments, coinsurance, deductibles, and elective treatments not covered by insurance. I understand that this authorization is for repeated transactions following confirmed office visits and that I will be notified before any additional charges outside of my standard copayment responsibilities.

I have had the opportunity to ask questions regarding these policies and understand my rights and responsibilities as a patient at Spine & Sports Injury Center.

By signing below, I confirm that I have read and understand this release and agree to its terms.

Signature: _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____