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: _____ Work: _____ 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:

_____

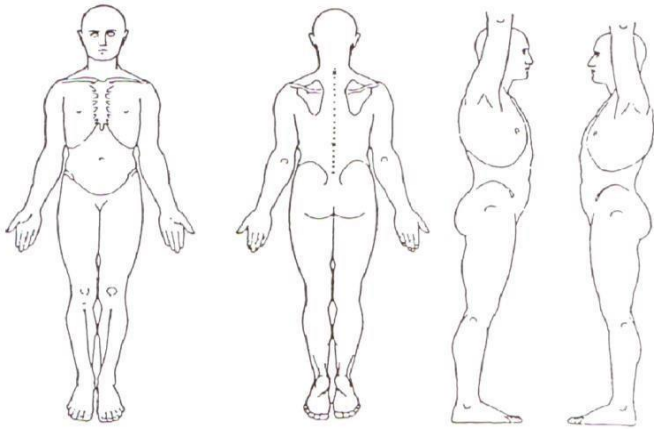
Have you been in an auto accident or had any other personal injury? ❍ Y ❍ N

Please Describe: _____

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Please rate the pain severity 0-10. Please locate your symptoms 0**=no pain 10=emergency room pain:**

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 OO=Tingling/Burning/Numb TT=Tight

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 ❍ Fibromyalgia
❍ Seizures/Epilepsy ❍ Thyroid
❍ Diabetes ❍ Asthma
❍ Heart Disease ❍ High Blood Pressure
❍ Other

Exercise Habits (gym, outdoors, walk to work)

_____

Fractures, sprains, strains, other past 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

❍ Smoking: Packs/Day_____ No. of years _____
❍ Liquor/Wine/Beer: Drink/Week _____ No. of Years _____
❍ Caffeine (coffee, tea, caffeinated sodas, energy drinks) Cups/Day _____

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Physician's Information

Primary Care Doctor:_____Affiliation_____

Phone:_____Fax:_____

Referring Physician:_____Affiliation_____

Phone:_____Fax:_____

Please initial if it's okay to send your initial examination notes to your primary care physician: _____

Consent to Use and Disclosure of Health Information

By signing this form, you are granting consent to Spine & Sports Injury Center, P.C. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (617) 247-2300. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Cancellation Policy

If you are unable to keep a scheduled appointment, please give us **24-hour notice**. (Please call on Friday for Monday appointments). When you receive your confirmation email and cannot keep your appointment, please call the office to cancel. If you miss a scheduled appointment or if you cancel an appointment within 24 hours, a **$50.00 fee** will be applied to your account. **NOTE**: Insurance companies will **NOT** pay for missed appointments.
I understand that I will be held responsible for any late cancellations or missed appointment and will pay $50.00 for each.

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Patient Disclaimer

I, the undersigned patient, in receiving care, treatment and other services from Spine & Sports Injury Center, P.C. (”Provider”) located at the CrossFit Invictus Gym at 209 Columbus Ave, Boston, MA, 02116, and at 133 Federal Street, 9th floor suite 902, Boston, MA 02110, hereby acknowledge that the relationship between the Club and the Provider is strictly that of a landlord and tenant, respectively. I further acknowledge that neither the club nor any person or entity affiliated with the Club has any responsibility or liability for any injuries, claims or damages arising from any treatment or other services performed by the Provider.

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed Doctor of Chiropractic and/or licensed physical therapists who may be employed or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and/or chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor physical therapy treatment is an exact science and that my care may involve judgments based upon facts and information unknown to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic and physical therapy health care, which includes rarely, but not limited to fractures, disc injuries, strokes, and sprains/strains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Health Insurance Procedures and Policies

Accepted Insurances

For Chiropractic Treatment, we are in network with Aetna, Blue Cross Blue Shield, Harvard Pilgrim, and Unicare. 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, Cigna/Tuft, and Allways Health Plans. Additionally, we accept Medicare, Workers Compensation, and Motor Vehicle Accidents for both Chiropractic and Physical Therapy. We will also accept any insurance not listed; subject to any out of network benefits which may include a higher deductible and coinsurance or copay. 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 Patients

For our patients without insurance, the initial visit for Chiropractic and Physical Therapy Treatment is $175.00 each. Each visit after the initial evaluation is $97.00. Services outside the normal range of treatment may incur additional fees, which will be discussed before treatment is commenced.

My signature below signifies that I understand the above insurance and billing information.

Name (print)_____Patient/Parent/Guardian Signature _____Date_____

Credit Card Payment Authorization Form

Sign and complete this form to authorize Spine and Sports Injury Center to make debits to your credit card listed below.

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. 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 copayment are due, and we will gain your verbal authorization before processing 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.

Please complete the information below:

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

Billing Address: _____ Phone: _____
City, State, Zip: _____ Email: _____

Account Type: Visa Mastercard Amex Discover HSA/Flex Account

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CVV: _____

I authorize the above-named business 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.