Bissell Clinic

Be Well. Live Well.

# Patient Information

Patient Name: _____ Email: _____

Address:_____City/State/Zip: _____

Home Phone:_____ Work: _____ Cell: _____

Social Security No: _____ Birth Date: ____/____/____ Age: _____

Gender: [m] [f] Marital Status: _____ Spouse's Name:_____

Race: [ ] White [ ] African American [ ] Asian [ ] Native American

[ ] Pacific Islander [ ] Other [ ]Decline

Emergency Contact:_____Phone:_____

How did you hear about us? [ ] Google [ ] Yelp [ ] Mailer [ ] Facebook

[ ] Advertisement [ ] Patient: name of person that referred you to our office: _____

Employer Name & Phone: _____

Primary Care Physician Name & Phone:_____

May we contact your primary care physician? □ YES □ NO

***Physical Therapy Patients with MEDICARE, please answer the following:***

*Are you receiving or have you recently received home health services?* □ *YES* □ *NO*

*Are you receiving or have you recently received other physical therapy services?* □ *YES* □ *NO*

# Bissell Clinic
# Consents & Office Policies

**Patient Name:**_____ **Date:** _____

**Financial/Office Policies:** I understand and agree to the following policies implemented by Bissell Clinic:

- Payment is expected when services are rendered unless prior arrangements have been made.
- **24-hour notice of cancellation is required to avoid a $50.00 charge for the missed appointment. The first late cancellation will be exempt from this charge.**
- A $25.00 service fee will be imposed for all checks returned for insufficient funds.
- You will be considered a cash patient until you provide us with your insurance card & we can verify your coverage.
- All accounts that are delinquent at 60 days are subject to a $25 penalty and will begin to accrue interest at 15% APR. Accounts will be reported to the credit bureaus for collection at 90 days.

**Please Initial: _____**

**Informed Consent:** I hereby request and consent to the performance of chiropractic adjustments and procedures and/or various modes of physical therapy including stretches and exercises, performed on or by me (or on the patient named above, for whom I am legally responsible) by Dr. Bissell, Dr. Rogers, Karen Still, M.S.P.T., Sara Avni, D.P.T., and/or those working at the clinic.
I recognize that all health care procedures, including those used in this office, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome and stroke or death through complicating factors. Physical Therapy exercises and stretches may result in muscle soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

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. I hereby accept the risks associated with any care by the doctor, therapists, and their assistants and release Bissell Chiropractic Clinic, Inc. of any liability for any injury or loss directly related to care I have received at this clinic.

**Please Initial: _____**

**Authorization of Payment:** I hereby assign all benefits directly to Bissell Clinic and also authorize the release of any medical records necessary to facilitate my treatment to process medical claims and a otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees (Civil Code 1717) as may be required to effect collection.
I further understand that any charges incurred for services rendered by an ancillary provider, radiology facility, or another chiropractor or physical therapist as a result of a referral made by Bissell Clinic Inc. may or may not be reimbursable depending on that clinic's contracted status with my insurance company. I realize that it is my responsibility to check this information prior to consenting to the procedure or treatment.

**Please Initial:_____**

**OVER →**

**You are responsible to pay for deductibles and co-pays at the time of service. If you prefer, you may leave your credit card on file. By signing below, you are authorizing us to make these charges to your card.**

Card # _____ Expiration Date: _____

Cvv: _____ Billing Address (#'s only): _____ Billing Zip Code: _____

Signature_____

**Treatment of Minors:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. I authorize Dr. Bissell, Dr. Rogers, Karen Still, M.S.P.T., & Sara Avni, D.P.T. & /or whomever they may designate as their assistant to administer treatment as deemed necessary.

**Please Initial:_____**

**Notice of Privacy Practices:** Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage & preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager, Michelle Jackson.

I acknowledge receipt of Notice of Privacy Practices.

**Please Initial**: _____

**I certify that all of the information provided herein is true & correct.**

Patient Signature _____ Date: _____

Witness Signature:_____ Date: _____

# PHYSICAL THERAPY INITITAL EVALUATION FORM

NAME_____ OCCUPATION_____

AGE_____ HEIGHT _____ WEIGHT_____lbs

**REHAB INFORMATION**

1. CHIEF COMPLAIN/AILMENT/INJURY _____
2. DATE OF INJURY _____ DATE OF SURGERY_____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED _____

_____

_____

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? □ YES □ NO WHEN?_____
5. HAS YOUR CONDITION BEEN GETTING: □ WORSE □ SAME □ BETTER
6. ARE YOUR SYMPTOMS: □ CONSTANT or □INTERMITTENT
7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: o 0 o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o 10 (EXCRUCIATING PAIN)
AT WORST: o 0 o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o 10 (EXCRUCIATING PAIN)

8. WHAT DECREASES PAIN /MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

| | | | |
|---|---|---|---|
| □ BENDING | □ MOVEMENT | □ REST | □ BETTER IN A.M. |
| □ SITTING | □ STANDING | □ HEAT | □ BETTER AS DAY PROGRESS |
| □ RISING | □ WALKING | □ ICE | □ BETTER IN P.M. |
| □ LYING | □ CHANGING POSITIONS | □ MEDICATION | □ N/A CAST JUST REMOVED |

9. WHAT INCREASES PAIN /MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

| | | | |
|---|---|---|---|
| □ BENDING | □ MOVEMENT | □ STAIR | □ WORSE IN A.M. |
| □ SITTING | □ STANDING | □ COUGH | □ WORSE AS DAY PROGRESS |
| □ RISING | □ WALKING | □ SNEEZE | □ WORSE IN P.M. |
| □ LYING | □ CHANGING POSITIONS | □ DEEP BREATH | □ N/A CAST JUST REMOVED |
| □ REST | □ PROLONGED POSITIONING | □ MEDICATION | |

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

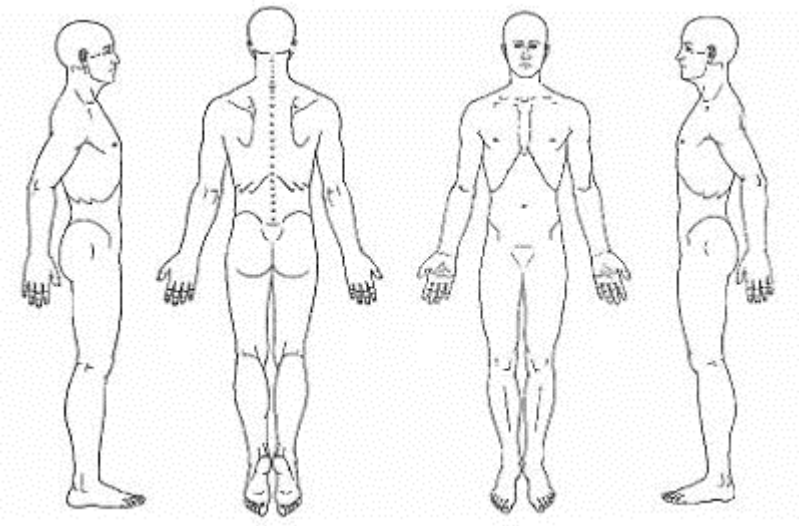
□ X-RAY / MRI □ CATSCAN □ INJECTIONS OTHER _____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

_____

**DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.**



| | |
|---|---|
| SEVERE PAIN | ****** |
| MODERATE PAIN | 000000 |
| ACHE / SORENESS | □□□□□ |
| SHARP/STABBING PAIN | ↓↑↓↑↓ |
| NUMBNESS/TINGLING | XXXXXX |

**MEDICAL INFORMATION** (MARK ALL THAT APPLY)

**This information is confidential and remains part of your chart

| | | | |
|---|---|---|---|
| □ Arthritis | □ Anemia | □ Bleeding Problems | □ Blood Clots |
| □ Cancer | □ Depression/Anxiety | □ Diabetes | □ Difficulty Swallowing |
| □ Epilepsy/Seizures | □ Fever/Chills/Sweats | □ Fibromyalgia | □ Heart Trouble |
| □ History of Drug Abuse | □ High Blood Pressure | □ HIV/Hepatitis | □ Motion Sickness/Vertigo |
| □ Osteoporosis | □ Pacemaker | □ Pregnancy | □ Shortness of breath |
| □ Stroke | □ Unexplained weight loss | □ Other: _____ | |

Previous Surgeries: _____

_____

Alcohol Consumption: □ do not drink □ 1-7/wk 8-14/wk □15+/wk

Smoking: □ Yes □ No

Medications: _____

Allergies: _____

Hobbies/Sports: _____