Hometown Spine & Sport
Chiropractic Rehab

Hometown Spine & Sport
7350 Steubenville Pike, Oakdale, PA 15071

Full Name: _____
Last: First: Middle Initial:

Mailing Address: _____
Street Address: Apt. #:

_____
City: State: Zip Code:

What name would you like our staff to address you by? _____

Cell Phone: _____ **Home Phone:** _____

Would you like appointment reminders to your cell or home phone? ☐ Cell/Tex ☐ Phone call

Email Address: _____ **Date of Birth:** _____

Social Security #: _____ **Age:** _____

Gender: ☐ Male ☐ Female

Height: ____ ft ____ in **Weight:** _____ lbs

EMERGENCY CONTACT INFO: Name: _____ Phone #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us (check one):
☐ Drove by ☐ Physician ☐ Google/Insurance ☐ Friend: _____

INSURANCE INFORMATION:

Are you the primary policy holder for your insurance? ☐ Yes (Check & skip to next page)
☐ No (Complete all fields below)

The primary policy holder is: ☐ Parent ☐ Spouse ☐ Other, Specify: _____

We need the following info for the primary policy holder:

Full Name: _____ **Date of Birth:** _____

Phone Number: _____ **Full Address:** _____

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Rate the severity of your pain (1 is mild pain to 10 severe pain: 1 2 3 4 5 6 7 8 9 10

Name of other Doctor(s) who have treated you for this condition: _____

What treatment have you already received for your condition:

☐ Medication _____ ☐ Surgery ☐ Physical Therapy ☐ Other _____

Previous Chiropractic care? If so, who? _____

List any types of surgeries with the associated dates: _____

_____

Please list all medications you are currently taking: _____

_____

NUTRITIONAL SURVEY:

Are you interested in Natural Medicine? ☐ Yes ☐ No

What kind of nutritional supplements do you take (if any)? _____

How often do you exercise? _____

Do you smoke? ☐ Yes ☐ No How much per day/week? _____

Do you consume alcohol? ☐ Yes ☐ No How much per day/week? _____

HEALTH HISTORY: check only those conditions that you have diagnosed with:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis
☐ Alcoholism	☐ Constipation	☐ Hernia	☐ Pinched Nerve
☐ Allergy Shots	☐ Depression	☐ Herniated Disc	☐ Pneumonia
☐ Anemia	☐ Diabetes	☐ Headaches	☐ Prostate Problems
☐ Appendicitis	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Epilepsy	☐ High Cholesterol	☐ Thyroid Problems
☐ Asthma	☐ Fractures	☐ Indigestion	☐ Ulcer
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Vaginal Infections
☐ Breast Lump	☐ Gout	☐ Miscarriage	☐ Other _____
☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	_____
☐ Cancer	☐ High Cholesterol	☐ Mumps	_____

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Are you here due to an accident that you filed a claim on (check one):
☐ Car Accident ☐ Work Accident ☐ Not Filing a Report or Claim/Not Applicable
Claim #: _____
Injury Date: _____
Rep's Name: _____
Rep's Phone #: _____

What areas of the body are bothering you (Be Specific):

_____
_____
_____
_____

When did your symptoms begin or when did they recently flair up again:

☐ Today ☐ Yesterday ☐ Last Week ☐ Two Weeks Ago ☐ This Month
☐ Last Month ☐ Other; specify date: _____

How often do you experience discomfort?
☐ Constantly (75-100% of awake time) ☐ Frequent (51-75% of awake time)
☐ Intermittent (26-50% of awake time) ☐ Occasional (0-25% of awake time)

When are your symptoms worst:
☐ Morning ☐ Afternoon ☐ Night ☐ Weather ☐ No Change

What helps relieve discomfort:
☐ Ice ☐ Heat ☐ Medication (Advil, Ibuprofen, etc.) ☐ Massage ☐ Nothing helps

What activities are limited by your discomfort:
☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine ☐ Driving
☐ Getting Up ☐ Lifting ☐ Lying Down ☐ Pulling ☐ Pushing ☐ Reading
☐ Urination ☐ Walking ☐ Working

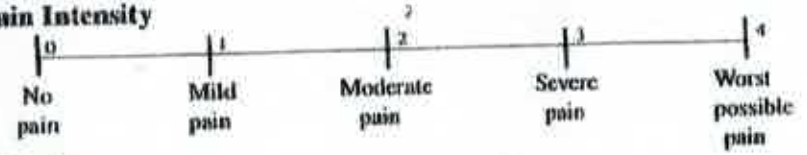
Please specify the most recent date of the following services:
Physical Exam: ___month, _____year
Spinal X-ray: ___month, ____year
MRI: ___month, _____year
Dental X-ray: ___month, ____year
CT Scan: _____month, _____year

Functional Rating Index

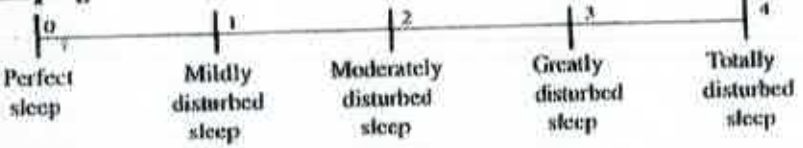
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

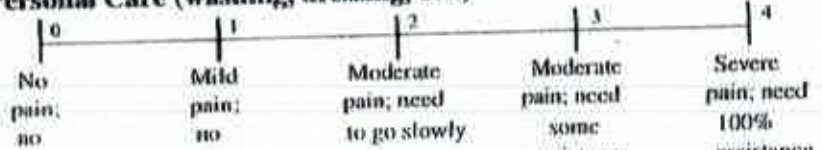
1. Pain Intensity



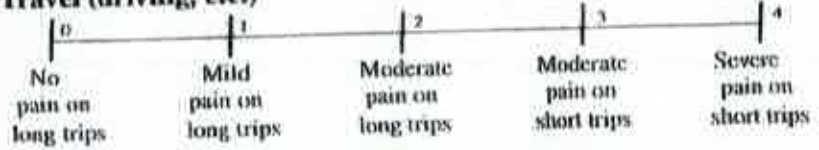
2. Sleeping



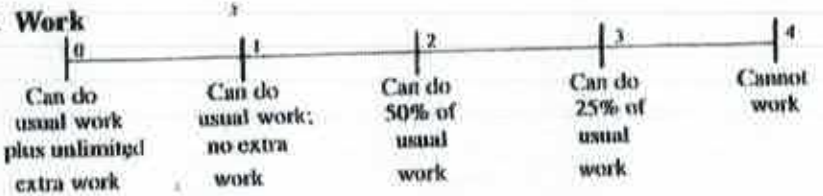
3. Personal Care (washing, dressing, etc.)



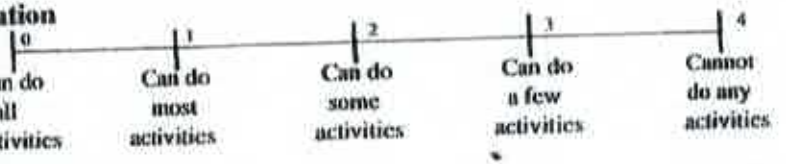
4. Travel (driving, etc.)



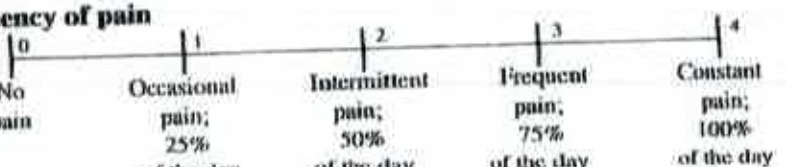
5. Work



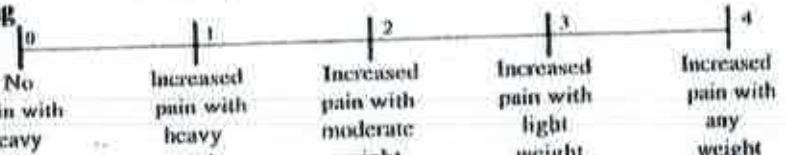
6. Recreation



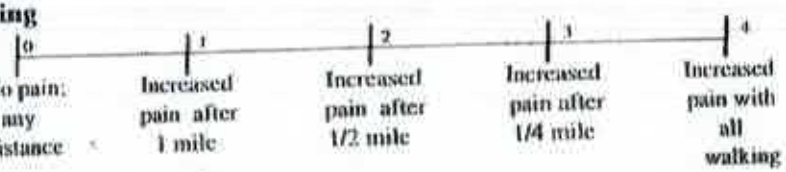
7. Frequency of pain



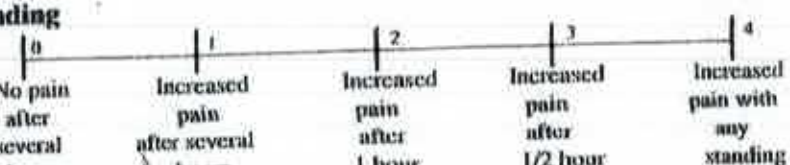
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____ **PRINTED**

_____
Signature

_____
Date

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CHIRORPACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct spinal restrictions allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Medical Records Release

By signing this form below, I authorize you to release confidential health information including but limited to radiology reports or a summary of my protected health information to Hometown Spine & Sport. **Fax: 412.490.6060, T: 412.490.1700**

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here:
http://www.cms.hss.gov/SecurityStandard/Downloads/securityproposedrule.pdf

Name of patient: _____ **Printed name of guardian/parent:** _____

Signature of patient: _____ **Signature of guardian:** _____

Date: _____

Completed by doctor

Reviewed by: Signature of doctor of chiropractic: _____ **Date:** _____

FINANCIAL POLICY

Hometown Spine & Sport believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, check, (except starter checks & not from new patients), MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service. There is a $25.00 bounced check service charge. Payment will then need to be made by cash, money order or credit card for the balance due.

When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made and of course a service fee will be generated.

Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.

Cancellation/ No Show Policy for Doctor Appointment: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance for 3 or more visits, then we reserve the authority to automatically discharge you from further care.

Scheduled Appointments: We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

I understand and agree to Hometown Spine & Sport Financial and Cancellation Policy.

Print Name: _____ Date: _____

Signature: _____