Patient Legal Name (First, MI, Last):____ Preferred name:_______________
Mailing Address: ____Sex: M / F / Other
Physical Address: ____Apt. #___________
City:______________________________ State:_________ Zip:__________________ Date of Birth:_____/_____/______
Social Security #:____________________ Marital Status: S / M / D / W E-mail Address:_________________________
Primary Phone #:__________________________________ Secondary Phone #:________________________________
We have permission to (please check all that apply):
- ❑ Leave messages on cell phone
- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone

Occupation: ___________________________________ Employer: ____
Emergency Contact:___________________________ Relationship:_________________ Phone #:__________________
Whom may we thank for referring you to our office?:____

Due to changes in health care, it is required by law to obtain the following information on patients in our office:
Language: English Spanish Russian Other(specify)_____________
Race: White Alaska Native Native American Decline to Answer Other(specify)____________
Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to Answer

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information

Who is the policy-holder?: Self Spouse Parent Employer Other

Policy Holder's Name: ____
Insurance Company:____ Group #:______________________
Policy/Member ID #:_______________________________________ Policy Holder's DOB: _____/____/_______

Do you have secondary insurance coverage? Yes No If yes, please complete the following:

Policy Holder's Name: ____
Insurance Company:____ Group #:______________________
Policy/Member ID #:_______________________________________ Policy Holder's DOB: _____/____/_______

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Premier Sports Medicine's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

Signature:____**Date:**_________________
(Patient / Legal Guardian of Minor)*
*Relationship to Patient: _______________________ Driver's License Number: _______________State_____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Assignment and Release

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

Signature:____**Date:**_________________
(Patient / Legal Guardian of Minor)

Consent of Professional Services and Release of Information

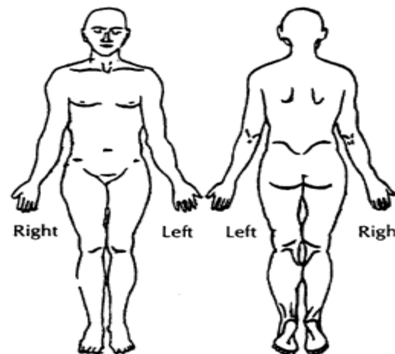
I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

- ❖ I authorize the staff to perform necessary services needed during diagnosis and treatment.
- ❖ I also authorize the provider to release information required to process insurance claims.

Signature:____**Date:**________________
(Patient / Legal Guardian of Minor)

Patient Name:________________________________
Reason for today's visit: ___Emergency ___New Injury ___Old Injury ___Chronic Pain
Date the injury/accident occurred and/or pain started? ___/____/______
Did your injury occur during: ___Work ___Sports ___Auto Accident ___Unknown ___Other
Is the condition interfering with your: ___Work ___Sleep ___Daily Routine ___Recreational Activities
Please explain what happened:____
Are you currently in Pain? **Y / N** Please rate your pain on a scale of 0–10 (worst pain imaginable):_______
Frequency of Pain: ___Constant (100%)___Frequent (75-95%)___Intermittent (50-75%)___Occasional (>50%) ____Only with Activity
Is the condition getting worse? **Y / N**
If yes, Please explain:______________________________________

***Using the body charts, please identify affected areas.**



Have you had imaging done of the affected area? If so, please list:
Date:__________ Facility:________________ Type: X-Ray / MRI / CT
Date:__________ Facility:________________ Type: X-Ray / MRI / CT

Have you been treated by a physician for this condition? **Y / N**
Clinic/Dr's Name:____

Has this or something similar happened in the past? **Y / N**
Please explain what happened:_______________________________

Have you ever been treated by a Chiropractor? **Y / N**
Clinic or Dr's Name:_______________________________________

Health History

Do you have or have had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack/Stroke	**Y N** Anemia	**Y N** Ulcer/ Colitis	**Y N** Rheumatic Fever
Y N Heart Surgery/Pacemaker	**Y N** Fainting/ Loss of Consciousness	**Y N** Kidney Problems	**Y N** Chicken Pox/Shingles
Y N High/Low Blood Pressure	**Y N** Concussion/ Brain Injury	**Y N** Fibromyalgia	**Y N** Tuberculosis
Y N Congenital Heart Defect	**Y N** Severe/ Freq. Headaches	**Y N** Arthritis:_______________	**Y N** Psychiatric Care
Y N Heart Murmur/Palpitations	**Y N** Seizures/ Epilepsy	**Y N** Osteoporosis/ Bone Disorder	**Y N** Alzheimer's/ Dementia
Y N Mitral Valve Prolapse	**Y N** Glaucoma/ Cataracts	**Y N** Cancer:_______________	**Y N** Anxiety/ Depression
Y N Artificial Valves/ Implants	**Y N** Sinus Problems	**Y N** Radiation/ Chemotherapy	**Y N** Alcohol/ Drug Abuse
Y N Artificial Bones/Joints	**Y N** Frequent Neck Pain	**Y N** Autoimmune Disorder(s)	**Y N** HIV+/AIDS/ARC
Y N Difficulty Breathing	**Y N** Lower Back Problems	**Y N** Nerve Disorder(s)	**Y N** Hepatitis
Y N Emphysema/COPD	**Y N** Diabetes Type I or Type II	**Y N** Measels/ Mumps	**Y N** Venereal Disease

Are you taking any of the following medications? ___Prescription Pain Killers __Muscle Relaxers __Blood Thinners
__Tranquilizers __Insulin __Hormones __Vitamins/Supplements __Steroids __Over the Counter Pain Management (Aleve, Tylenol, etc.)

Please list any/all medications (including supplements):____
____
Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:__________________
____
List any past serious accidents with dates:____
____
Please list anything that you may be allergic to: ___Food ___Environment ___Medications ___No Known Allergies
____
Family Health History:____
____
Do you exercise? **Y / N** How often? ___Daily ___Weekly ___Monthly
Have you worn/ Are you wearing?: ___ Shoe lifts ___ Inner soles ___ Arch supports ___Orthopedic Shoes
Do you use tobacco products? ___Former Smoker ___Never ___Occasionally ___Frequently ___Daily
Do you drink alcohol? ___Never ___Occasionally ___Frequently ___Daily
For women:
Are you taking Birth Control? **Y / N** Are you nursing? **Y / N** Are you pregnant? **Y / N** If so, how many weeks?________

- We invite you discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____
Print Patient Name **Signature of Patient/Legal Guardian** **Date**

HIPAA Release

In the course of your care as a patient at Premier Sports Medicine we may use or disclose personal and health related information about you in the following ways:

* Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
* Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMP, a PPO, or your employer (if they are or may be responsible for the payment of your services).
* Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
* Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances: If we are providing health care services to you based on the orders of another health care provider; in an emergency; if we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so; if there are substantial barriers to communicating with you; if we are ordered by the courts or another appropriate agency.
* You have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.
* We are required by state and federal law to maintain the privacy of the patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.
* We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this notice.
* If you have a complaint regarding our privacy notice or would like further information about our privacy policies and practices, please contact Dr. Brian E. Larson.

This notice is effective as of January 1st, 2019. This notice will expire seven years after the date upon which the record was created. I understand that these privacy practices will be followed by *Premier Sports Medicine* to ensure the privacy of my personal health information. I understand this form will be placed in my patient chart and maintained for seven years. My signature acknowledges that I have received a copy of this notice.

____

Print Patient Name **Signature of Patient/Legal Guardian** **Date**

Please list below the name(s) and your relationship of people with whom you authorize *Premier Sports Medicine* to release your private health information.

Name:_______________________________________**Relationship:**______________________

Authorization to:
- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future appointments
- ❑ Receive phone messages and/or email regarding appointments or test results

This authorization is effective through (check one):
- ❑ ____ /____ /____
- ❑ NO EXPIRATION unless revoked or terminated by the patient or the patient's personal representative

Name:_______________________________________**Relationship:**______________________

Authorization to:
- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future appointments
- ❑ Receive phone messages and/or email regarding appointments or test results

This authorization is effective through (check one):
- ❑ ____ /____ /____
- ❑ NO EXPIRATION unless revoked or terminated by the patient or the patient's personal representative

Name:_______________________________________**Relationship:**______________________

Authorization to:
- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future appointments
- ❑ Receive phone messages and/or email regarding appointments or test results

This authorization is effective through (check one):
- ❑ ____ /____ /____
- ❑ NO EXPIRATION unless revoked or terminated by the patient or the patient's personal representative

____

Print Patient Name **Signature of Patient/Legal Guardian** **Date**

I understand that I may revoke this authorization to disclose information at any time by notifying Premier Sports Medicine in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Premier Sports Medicine until the termination request is received in writing and processed.

Informed Consent to Care/Treatment

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed decisions. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examination or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation within a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in 1 in one million to 1 in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million persons per year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every potential complication to care. I have also had an opportunity to ask questions about it's content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ____ Date:______________

Patient Signature: ____ Date:______________

Parent/Guardian Signature: __________________________________Date:______________

<u>Financial Policy</u>

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS or VISA/MASTERCARD

Regarding Insurance

We accept assignment of insurance benefits after deductibles (if applicable) are met. Co-payments are due at time of service. We cannot bill your insurance company unless you provide your insurance information. **<u>Your insurance policy is a contract between you and your insurance company. This office is not a party to that contract.</u>** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. <u>You are responsible for payment regardless of the insurance company's final determination.</u> Dr. Larson is a Specialty Licensed Sports Physician; therefore insurance rates may vary for specialist care.

Adult Patients

Adult patients are responsible for full payment at time of service, unless other payment arrangements are made in advance.

Minor Patients

The adults accompanying a minor and the parents/guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized and an approved payment plan has been set in place.

Student Athletes

The treatment of injuries on the field or outside of the clinic fall under Dr. Larson's volunteered time. Charges and fees do not apply when treatment is rendered on the field/court. However, the moment a student athlete walks through the clinic doors charges and fees will apply.

Missed Appointments

Unless cancelled in 24 hours in advance, our policy is to charge for missed massage appointments. The fee is $50. We do not charge for missing chiropractic appointment, but please let us know in advance so we can fill that appointment. After four consecutive missed appointments, the front desk staff will cease to schedule until such a time that truancy fees have been satisfied.

Interest

Premier Sports Medicine reserves the right to charge interest in the amount as provided by state law.

<u>Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.</u>

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature: ____ **Date:** __________________

Signature of Patient or Responsible Party