Elite Health Solutions

Chiropractic Rehab Wellness

Patient Background Information

First Name: _____ Last Name: _____Nickname: _____

Date of Birth: _____ Age: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Cell

Phone: _____ Home Phone: _____ Permission to Text? Yes / No

Email Address: _____

Primary Care Doctor: _____ May we contact in regards to your visit? Yes / No

How did you find us? _____

Employer

Employer Name: _____ Employer Phone #: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Credit Card Information

(AMEX not accepted)

Cardholder Name: _____

Card Number: _____ CVC: _____ Exp. Date: _____

Street Address (if different than above): _____

City: _____ State: _____ Zip Code: _____

*This credit card information will be used only if a no-show or cancellation fee will be charged. Your signature to this document indicates your acceptance of these charges as set forth herein. You will be informed when any of these charges occur. A receipt will be provided on request.
If you miss three consecutive appointments without canceling them in advance, all future appointments will be cancelled, and Elite Health Solutions will assume you no longer wish to seek care with us. This is our "three strike" policy. In that case, you will be discharged from our practice. You will then need to seek care elsewhere. In these cases, I may not provide you with referrals, and you may need to contact your insurance company.

Patient Name: _____ Date: _____

Signature: _____

Financial Policy

Insurance Coverage

Welcome to **Elite Health Solutions.** We are a self-pay practice but will gladly submit to your insurance if requested. Any and all insurance benefits will be paid to the insured.

Payments

In order to help you determine how you would like your billing handled, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to submit to my insurance. I understand I am responsible for the costs of treatment and agree to keep my account current by paying for each visit at the time services are rendered

Missed Appointments

It is the policy of **Elite Health Solutions** to assess a **$90** missed visit fee to patients who miss their appointment. If you are more than 15 minutes late to your scheduled appointment time, your appointment will be cancelled and you will be charged the full amount for your visit. Cancelled appointments with less than a 24-hour notice will be assessed the missed visit fee of **$90.** One cancelled visit with less than 24-hour notice will not result in the assessment of the fee, but you will be charged for any additional late cancelled visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____**My initials here indicate that I understand the above missed visit policy.**

Insurance Information

Insured Relation: _____ **Insured Full Name** _____
Insured Street Add *(if different from patient)*: _____
Insured City: _____ **Insured State:** _____ **Insured Zip:** _____
Insurance Company: _____
Insurance Group #: _____
Insurance Policy Number: _____

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____
Signature Date

Informed Consent to Care

By reading and signing this form, I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x---rays, on me (or on the patient names below, for whom I am legally responsible) by the doctors of chiropractic and qualified staff members at **Elite Health Solutions** who are employed now or in the future. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures such as Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. One in a million is about the same chance as getting hit by lightening. One in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Finally, I am aware that the appropriate tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm, However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter medications, exercises and possible surgery. **Medications**: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. **Rest/Exercise**: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. **Surgery**: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovers. **Non---treatment**: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Notice of Privacy Policy

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. If applicable, we may disclose your health information, as deemed necessary by law, to comply with state Workers' Compensation Laws, in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, preapproved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restriction on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with your physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available by us upon request, or at https://www.hhs.gov/hipaa Questions, concerns, and/or complaints should be directs to DHHS, Office of Civil Rights 200 Independence Ave., S.W. Room 509F HHH Building in Washington, DC 20201.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing of this consent form. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Name: _____ Patient Signature: _____

Date: _____

2023 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or **NO**.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.(ask front desk)

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.