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: _____

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: _____

Insurance

(if applicable)

Insured Relation: _____ Insured First Name: _____
Insured Last Name: _____ Insured DOB: _____
Insured Street Address: _____
Insured City: _____ State: _____ Zip Code: _____

Insurance Company: _____
Insurance Street Address: _____
Insurance City: _____ State: _____ Zip Code: _____

Insurance Group # _____ Insurance Policy Number: _____

Legal Representation

(If Applicable/Personal Injury Case)

Law Firm: _____ Phone #: _____
Lawyer First Name: _____ Lawyer Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

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Financial Policies

Payment is due at the time services are rendered

AUTHORIZATION INSURANCE BENEFITS, IRREVOCABLE ASSIGNMENT, AND LIEN

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier, to pay directly to **Elite Health Solutions LLC** such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect **Elite Health Solutions LLC**. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by **Elite Health Solutions LLC**. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien, and Authorization do not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization and authorize and direct **Elite Health Solutions LLC** to appeal denials or payments at all levels on my behalf.

I agree never to rescind this document and that a rescission will not be honored by my insurance company. I hereby instruct that in the event another insurance company is substituted in this matter, the new insurance company will honor this agreement as inherent to the settlement and enforceable on the case as if it were executed by the company.

Patient Signature_____ Date: _____

Patient Name (Printed) _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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Missed Appointments, No-shows:

Appointments with chiropractors are like other medical appointments. Scheduled appointments are times held specifically for you. At Elite Health Solutions, we do not schedule anyone else for that time. Although our availability for our visits may be disrupted by emergencies (rarely), we work hard to ensure that we are available for you at our scheduled appointment time.

You will be charged **$25.00** as a missed appointment fee if you do not come to your appointment. This will be waived if you have called to cancel the appointment by within 24 hours prior to your scheduled appointment. If you feel that you have been unable to come to your appointment due to a valid emergency, please call or e-mail us to discuss waiving the missed appointment fee.

Insurance companies do not reimburse for missed appointments, so you will be responsible for paying the missed appointment fee with your own money.

*You will be asked to fill out a reserve credit card form**. This will be used only on your request**, if a no-show fee will be charged, for payment of fees, or if there is a balance on the account after discontinuation of services. 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 "3 strikes and you're out" 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.

Print Name:_____ Signature:_____ Date: _____

(Even if you do not fill out the Credit Card Information,
please sign the above to certify that you have read this page)

Credit Card Information:

Cardholder Name: _____

Card Number: _____

Expiration Date:_____ CVV Security Code: _____

Address:_____

City:_____ State:_____ Zip Code: _____

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: _____

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

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