SPRINGCREEK
MEDICAL CENTER

First Name: _____ **Last Name:** _____ **Date:** _____

SS#: _____-_____-_____ **DOB:** __ __/__ __/__ __ **Age:** _____ **Gender:** Male/Female

Address: _____

Phone: _____ **Email address:** _____@_____

Preferred method of contact: Email / Phone / Text **Preferred Language:** _____

Height: _____ **Weight**: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Smoking Start Date (Optional): _____

Primary care physician: _____
Do we have permission to contact your doctor regarding your care in our office? _____ Yes _____ No

Occupation: _____ **Employer:** _____

Do your work activities mostly involve: □Sitting □Standing □Light Labor □Heavy Labor

Marital Status: Single Married Divorced Widowed Separated Minor

Emergency Contact: _____ **Phone #:** _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

How did you hear about this office (Circle One)? Google/internet Radio Existing patient Other

Do you have health insurance? ___ Yes ___ No
Do you have secondary coverage? ___ Yes ___ No

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage, and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Springcreek Medical Center, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Insurance Name: _____ **Member ID:** _____
Policy Holder's Name: _____ **Policy Holder's DOB:** _____

SIGNATURE (X) _____ **DATE** _____

PATIENT HEALTH HISTORY

What are the goals your hoping the achieve with us? _____
_____

Please circle if you have had any of the following:

- ADD/ADHD
- Aids/HIV
- Allergy Shots
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- High or Low Blood Pressure
- Breast Lump
- Broken Bones
- Bronchitis
- Cancer
- Diabetes
- Eating disorders
- Epilepsy
- Fractures
- Gall Bladder
- Glaucoma
- Heartburn
- Heart Attack
- Hepatitis
- Herpes
- High Cholesterol
- Hormone Problems
- Insomnia
- Kidney Problems
- Liver Disease
- Migraines
- Miscarriage
- Multiple Sclerosis
- Osteoporosis
- Pacemaker
- Parkinson's disease
- Pinched Nerve
- Pneumonia
- Psychiatric Care
- Stroke
- Thyroid Problems
- TMJ Pain
- Tonsillitis
- Tremors
- Tumors/Growths
- Whooping Cough
- Other: _____ _____ _____

Are you currently taking any medications? (Continue onto back if needed)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? (Continue onto back if needed)

Medication Name	Reaction	Onset Date	Additional Comments

Preferred Pharmacy: _____

Please list any surgeries: _____
_____

Is there a family history of any of the following conditions? ***(Indicate family member including parents, grandparents & siblings)***

- Heart Disease_____
- Diabetes _____
- Cancer _____
- Arthritis _____
- Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

What is your daily/weekly intake of the following? Caffeine _____cups/day Alcohol _____drinks/week

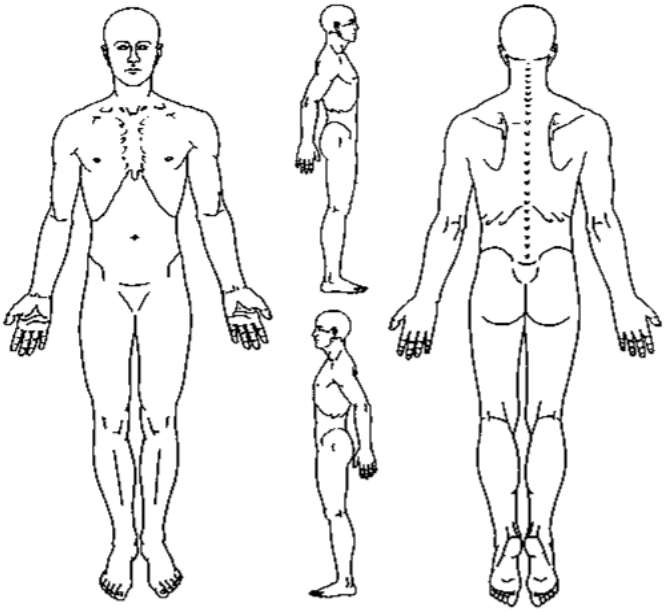
Is your care with us due to an accident?_____ If yes, how long ago?_____

Have you ever received chiropractic care? Y N If yes, how long ago? _____

Have you ever received physical therapy? Y N If yes, how long ago?_____

Please mark if you are currently experiencing any of the following and circle on diagram your areas of pain:

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Arm/Hand Pain
- ☐ Leg/Knee Pain
- ☐ Headaches
- ☐ Night Pain
- ☐ Depression
- ☐ Cold Extremities
- ☐ Nervousness
- ☐ Sleeping Difficulties
- ☐ Jaw Problems
- ☐ Loss of Smell
- ☐ Fainting
- ☐ Dizziness
- ☐ Stomach Problems
- ☐ Asthma
- ☐ Swollen Joints
- ☐ Mood Changes
- ☐ Foot Trouble
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Light Bothers Eyes
- ☐ Recent Weigh Change
- ☐ Loss of Memory
- ☐ Nausea
- ☐ Loss of Taste
- ☐ Fatigue
- ☐ Chest Pain
- ☐ Tension
- ☐ Fever
- ☐ Cold Sweats
- ☐ Constipation/Diarrhea
- ☐ Allergies
- ☐ Shortness of Breath
- ☐ Blurred/Double Vision
- ☐ Bowel/Bladder Changes
- ☐ Trouble Concentrating
- ☐ Loss of Balance



Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES

Do your hands or arms fall asleep regularly? NO YES

Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES

Do you suffer from a loss of handgrip strength? NO YES

Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES

Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES

Do our legs or feet fall asleep regularly? NO YES

Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES

Do you suffer from cold hands or feet? NO YES

Do suffer from seasonal or year round allergies? NO YES

Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES

Have you had an MRI? NO YES
If yes: When? Who ordered it? What was it ordered for?
_____

Have you used any splint or braces or other prescribed treatment by an MD? NO YES
If yes: When? What kind? Who ordered it?
_____

Please check ALL options you have previously tried to assist in above symptoms:

____ Supplements ____ Alternative medication
____ Dietary Changes ____ Exercise

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Y or N
If yes, what_____ When_____

Review of Systems

Please mark if you have ever had any of the following:

Neurological
___ Migraines
___ Headaches
___ Slurring of speech
___ Ringing in Ear

Ear/Nose/Throat
___ Altered taste/smell
___ Night Blindness
___ Sore Throat
___ Gingivitis
___ Nose bleeds

Cardiovascular
___ Chest pain
___ Palpitations-racing heart beat
___ Swelling in hands/feet
___ Anemia

Respiratory
___ Recurrent Respiratory Infections
___ Asthma
___ Chest Congestion
___ Wheezing
___ Frequent Sneezing

GI
___ Stomach Pains or Cramping
___ Constipation
___ Reflux or Heartburn
___ Bloating
___ Gas
___ Nausea or Vomiting

Musculoskeletal
___ Joint Pain
___ Arthritis
___ Chronic pain
___ Muscle Aches

Skin
___ Eczema
___ Dermatitis
___ Excessive Sweating
___ Rashes
___ Brittle Nails
___ Hair Loss
___ Easy Bruising
___ Increased Bleeding
___ Numbness/tingling

Genitourinary
___ Uterine fibroids
___ Ovarian cysts
___ Cancer
___ Prostate problems

Emotional/Mental
___ Depression
___ Anxiety
___ Mood Swings
___ Irritability
___ Memory Loss
___ Confusion

Energy
___ Fatigue
___ Hyperactivity
___ Restlessness
___ Insomnia
___ Decreased Libido
___ Stress

Weight
___ Decreased Appetite
___ Weight Gain
___ Inability to Lose Weight
___ Food Cravings
___ Binge Eating
___ Water Retention

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.

SIGNATURE (X) _____ DATE _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **SPRINGCREEK MEDICAL CENTER**, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

I hereby acknowledge that I will be held accountable for incurred balances on my account. I understand I am responsible for any non-sufficient funds transaction and associated fees. I further acknowledge if balances are deemed delinquent account will be turned over to the collection agency. And that I am responsible for all fees associated with the delinquency of my account.

Signed this _____ day of _____ 20 ____.

X_____ _____
(Patient Signature) (Printed Patient Name)

X_____ _____
(Signature of Guardian/Representative if applicable) (Printed name of Guardian/Representative)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of **SPRINGCREEK MEDICAL CENTER**. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

"No Show" and "Cancellation" Policy and Procedure for Office Visits

At Springcreek Medical Center, our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy to better utilize available appointments for our patients in need of care. The following policy is with regard to patients who fail to keep their scheduled appointment.

To be courteous to all of our patients we ask you to call us promptly if you are unable to attend an appointment, so this time can be reallocated to someone who is in need of care. Available appointments are in high demand and your early cancellation will give another person the ability to have access to timely care.

In the event of an actual emergency consideration will be given, and a <u>one-time</u> exception may be granted.

- Chiropractic Patients:
  Patients who fail to show for their scheduled appointment or do not notify the office at least 24 hours in advance from appointment time, shall be subject to a **"No Show/Cancellation"** fee of **$25.00**.

- Physical Therapy Patients:
  Patients who fail to show for their scheduled appointment or do not notify the office at least 24 hours in advance from appointment time, shall be subject to a **"No Show/Cancellation"** fee of **$35.00**.

- Nurse Practitioner Patients:
  Patients who fail to show for their scheduled appointment or did not notify the office at least 24 hours in advance from appointment time, shall be subject to a **"No Show/Cancellation"** fee.
  If scheduled for a 1 hour appt. a one-time exception is given, after which a cancellation fee of **$55.00** will be charged.
  If scheduled for a 30 min. apt. a one-time exception is given, after which a cancellation fee of **$25.00** will be charged.

- **These fees are not covered by insurance and is therefore the sole responsibility of the patient.**

How to Cancel Your Appointment

To cancel or reschedule appointment call our number **435-792-9400**. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature: _____ Date: _____

Patient Printed Name: _____