First Name________________________ **Last Name**_________________________ **Suffix**____________

Preferred Name_______________________ **Gender** ☐ Male ☐ Female **DOB**_____/______/________

SS#______-_____-_______ **Phone** (_____) _______________ **Email**_________________________________

Guarantor Information (to be completed for minors under the age of 18 or disabled persons)
Name______________________________ **DOB**_____/____/______ **Phone**________________

Address___________________________________ **City/State/Zip**__________________________________

Primary Care Physician____ **Can we contact?** ☐ 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** (______) __________________

List those whom you want to have access to your health records_________________________________

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Decline to Answer

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

How did you hear about this office? ☐ Google ☐ Internet ☐ Radio ☐ Existing Patient

☐ Referral Physician If referred, name of physician _____________________________________

Do you have health insurance? ☐ Yes ☐ No **Do you have secondary coverage?** ☐ Yes ☐ No

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 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_____________________ Effective Date___________

Policy Holder's Info – Name_________________________ DOB____/_____/_____ Relation____________

Signature ____ Date ________________________

PATIENT HEALTH HISTORY

Is your care with us due to an accident? ☐ Yes ☐ No **If yes, how long ago?** ________________________

Have you ever received chiropractic care? ☐ Yes ☐ No **If yes, how long ago?** _____________________

Have you ever received physical therapy? ☐ Yes ☐ No **If yes, how long ago?** _______________________

What are the goals you are hoping to achieve with us? ____

____

Please check the boxes for any of the following conditions that you have had:

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

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

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

Do you have allergies to any medications? (Continue on back if needed)

Medication Name	Reaction	Onset Date	Additional Comments

Preferred Pharmacy____________________________________ **Height**___________ **Weight**___________

Smoking Status ☐ Every day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Smoking start date____________________

List any surgeries you've had____

____

Family History of any of the following (state relation including grandparents, parents, and siblings)

Heart Disease_____________________ **Diabetes**______________________ **Cancer**___________________

Arthritis________________________ **Other**____

Do you exercise ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

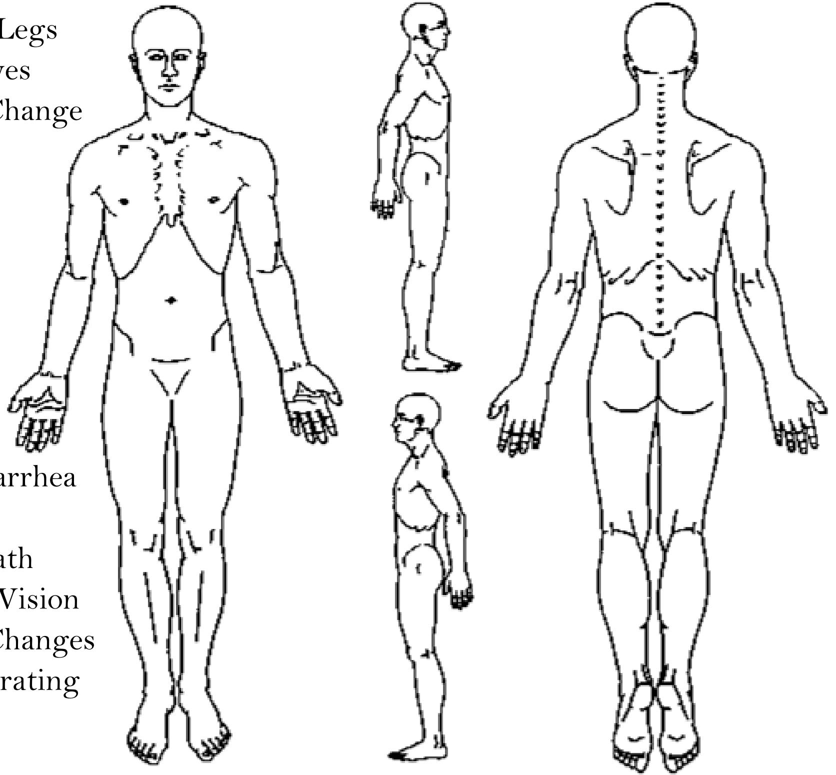
Do you sleep on your ☐ Back ☐ Side ☐ Stomach

What is your daily/weekly intake of the following caffeine ______cups/day alcohol_______ drinks/week

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

☐ 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

☐ Pain/Needles in Arms
☐ Pins/Needles in Legs
☐ Light Bothers Eyes
☐ Recent Weight 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? Yes No

Do your hands fall asleep regularly? Yes No

Do you have reduced feeling (sensation) or swelling in your hands or arms? Yes No

Do you suffer from a loss of handgrip strength? Yes No

Do you suffer from back pain with pain in your buttocks, legs or feet? Yes No

Do you have weakness, numbness or burning in your buttocks, legs or feet? Yes No

Do your legs fall asleep regularly? Yes No

Do you have reduced feeling (sensation) or swelling in your legs or feet? Yes No

Do you suffer from cold hands or feet? Yes No

Do you suffer from seasonal or year round allergies? Yes No

Do you suffer from headaches? Yes No

If yes, how often, how severe, and what has been tried? ______________________________

Have you had an MRI? Yes No

If yes, when? Who ordered? What for? ______________________________

Have you used splints, braces, or other prescribed treatment by a medical doctor? Yes No

If yes, when? What kind? Who ordered? ______________________________

Check ALL options you have previously tried to assist in the above listed symptoms

☐ Supplements ☐ Alternative Medication ☐ Dietary Changes ☐ Exercise ☐ Other

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Yes No

If yes, what? When? ______________________________

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: ___________________

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 ____ **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.

I hereby agree to receive electronic (email and/or text) communications including, but not limited to, office communication and billing.

Date ______________________

_________________________________ _________________________________
(Patient Signature) (Printed Patient Name)

_________________________________ _________________________________
(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. **I acknowledge that have read and understand the above consent form.**

Signature ______________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of **SPRINGCREEK MEDICAL CENTER**.
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.

We understand that life happens and in the event of an emergency, consideration will be given, and a one-time exception may be granted.

Patients who fail to show for their scheduled appointment or do not notify the office within 24 hours in advance, shall be subject to a “No Show/Cancellation” fee as follows:

- **Chiropractic - $35.00**
- **Massage Therapy - $25.00**
- **Physical Therapy - $35.00**
  - **Evaluations - $65 – No exceptions are given**
- **Nurse Practitioner - $25**
  - 1 hour appt. - **$55.00 - No exceptions are given**.

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

To cancel or reschedule an appointment, **call** 435-792-9400, **text** 435-465-1402, or **email** springcreekmedicalcenter@gmail.com.

Patient/Guardian Signature________________________________ Date__________________

Patient/Guardian Printed Name__________________________________