AIKEN PHYSICAL MEDICINE

Application for Patient Care

PATIENT INFORMATION

Salutation: ___Ms. ___Mrs. ____Mr. ___Dr.
First Name: _____ M.I.: _____ Last Name: _____
Address: _____City_____State____Zip_____
SS#: _____-_____-_____ Age: _____ DOB: __ __ /__ __ /__ __ Male / Female
Phone: (c)_____ (h)_____ Email: _____
Primary Care Physician: _____
Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No
Occupation: _____ Employer: _____
Type of Tasks Performed/Common Movements: _____
If retired, what from? _____

Marital Status: __Single __Married __Divorced __Widowed __Separated __Minor
Spouse's Name:_____ Spouse's DOB:_____ # of Children:_____
Emergency Contact Name: _____ Relation: _____ Phone #:_____

HISTORY

Have you had a recent fall/other accident? __0-6mo __6 mo-1 yr __1-3yrs __3+yrs __Never
Have You Ever Received Chiropractic Care? __Yes __No Last Visit?_____
Have You Ever Received Physical Therapy? __Yes __No Last Visit?_____
Date of your most recent Medical Physical Examination? _____

REFERRALS

How Did You Hear About This Office?
__Walk-In/Drive-By/Saw sign
__Social Media
__Magazine
__TV which channel:_____
__Newspaper Ad
__Existing Patient: _____
__Radio: _____
__Internet, which site: _____
__Ad:_____
__Community Event: _____
__Other: _____

INSURANCE ASSIGNEMNT & CONSENT

Do you have health insurance? __Yes __No Name of Carrier: _____
Do you have secondary insurance? __Yes __No Name of Carrier: _____

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions Group, LLC, ALL APPLICABLE 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.

AIKEN PHYSICAL MEDICINE

PATIENT HEALTH HISTORY

Is there a family history of: __Heart Disease __Diabetes __Cancer __Arthritis
Other:_____

MEDICAL HISTORY

PLEASE CHECK TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THESE CONDITIONS IN THE PAST OR PRESENT
IF THE CONDITION IS A PAST CONDITION PLEASE INDICATE THE YEAR IN THE SPACE PROVIDED
USE THE BACK OF THIS SHEET IF MORE SPACE IS NEEDED FOR CONDITIONS NOT LISTED

_____Anemia
_____Anorexia
_____Arthritis
_____Back Pain
_____Bacterial Infection
_____Bleeding Disorders
_____Blood Pressure: High
_____Blood Pressure: Low
_____Breast Lump
_____Broken Bones
_____Bulimia
_____Cancer
_____Chemical Dependency
_____Chest Pain
_____Deafness
_____Diabetes
_____Epilepsy
_____Fibromyalgia
_____Fractures
_____Foot Pain
_____Gout
_____Heart Attack
_____Heart Problems
_____Hepatitis
_____Herniated Disc
_____Hernia
_____Hormone Replacement
_____Gland Problems
_____Migraines
_____Multiple Sclerosis
_____Neck Pain
_____Neuropathy
_____Osteoporosis
_____Pacemaker
_____Pinched Nerve
_____Prosthesis
_____Rheumatoid Arthritis
_____Rheumatic Fever
_____Stroke
_____TMJ Pain
_____Tuberculosis
_____Tumors/Growths
_____Ulcers
_____STD/AIDS/HIV
___Other_____
___Other_____
___Other_____
___Other_____
___Other_____
___N/A (no medical history)

Have you had any of the following tests performed:
EKG Test: __No __Yes Date:_____ MRI: ___No ___Yes Date:_____
Allergy test: ___No ___Yes Date:_____ Other Test(s):_____

Please list any surgeries and/or hospitalizations you have had (type & date):_____
_____

What is your current intake of:
Caffeine ____cups per day
Alcohol ____drinks per week
Cigarettes _____packs per day
Sugar_____amount per day
Sodas_____amount per day

Do you have a history of:
Cigarettes ____packs per day
Alcohol___drinks per week
Drug use _____type and quantity
Sugar_____amount per day
Sodas_____amount per day

X-ray Questionnaire: For women only: Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. **Please choose one of the options below:**
____I may be pregnant at this time ____Yes, I am definitely pregnant ___No, I am definitely not pregnant
Last menstrual period: _____ I request that x-ray films not be taken because:_____

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 _____

AIKEN PHYSICAL MEDICINE

REVIEW OF SYSTEMS
HISTORY & PHYSICAL

***PLEASE CHECK TO INDICATE IF YOU HAVE HAD ANY OF THESE SYMPTOMS OR CONDITIONS (MILD, MODERATE, OR SEVERE) IN THE LAST 12 MONTHS*:**

Y N

Neurological
___ ___ Migraines
___ ___ Headaches
___ ___ Slurring of Speech
___ ___ Ringing in Ear(s)
___ ___ Dizziness
___ ___ Paralysis

Eye/Ear/Nose/Throat
___ ___ Altered Taste or Smell
___ ___ Night Blindness
___ ___ Sore Throat
___ ___ Nose Bleeds
___ ___ Ear Infections
___ ___ Sinus infections
___ ___ Hay fever

Cardiovascular/Endocrine
___ ___ Chest Pain
___ ___ Palpitations or Racing Heart Beat
___ ___ Swelling in Hands/Feet
___ ___ Anemia
___ ___ Hypoglycemia
___ ___ Hyperglycemia
___ ___ Thyroid: Low or High (circle one)

Respiratory
___ ___ Recurrent Respiratory Infections
___ ___ Asthma
___ ___ Wheezing
___ ___ Chest Congestion
___ ___ Frequent Sneezing
___ ___ Pneumonia
___ ___ Frequent Cough
___ ___ Bronchitis

Gastrointestinal (GI)
___ ___ Stomach Pains or Cramping
___ ___ Constipation
___ ___ Reflux or Heartburn
___ ___ Bloating
___ ___ Gas
___ ___ Nausea or Vomiting
___ ___ Cancer
___ ___ Irritable Bowel Syndrome (IBS)

Musculoskeletal
___ ___ Joint Pain
___ ___ Arthritis
___ ___ Chronic Pain
___ ___ Muscle Aches
___ ___ Rheumatoid Arthritis
___ ___ Osteoarthritis (generalized)

Y N

Skin
___ ___ Eczema
___ ___ Dermatitis
___ ___ Excessive Sweating
___ ___ Rashes
___ ___ Brittle Nails
___ ___ Hair Loss
___ ___ Easy Bruising
___ ___ Increased Bleeding
___ ___ Acne/Rosacea
___ ___ Dry or Itchy Skin

Genitourinary
___ ___ Uterine Fibroids
___ ___ Ovarian Cysts
___ ___ Cancer (Breast, Ovarian, Prostate, Uterine)
___ ___ Prostate Problems

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

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

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

Please provide any and all health issues not listed here:

_____
_____
_____
_____
_____

AIKEN PHYSICAL MEDICINE

Patient Name:_____ D.O.B._____ Date _____

Smoking Status (Circle one):

Every Day Smoker Occasional Smoker Former Smoker Never Smoked

Smoking Start Date (Optional): _____

If you smoke, do you want to stop smoking? YES NO

Please list any and all medications that you are currently taking:

1._____

2._____

3._____

4._____

5._____

6._____

If you are currently taking more than six medications please provide this office with a list of all medications.

Are you allergic to any medications? YES NO
If so, please list:

1._____

2._____

3._____

4._____

5._____

6._____

If you are allergic to more than six medications please provide this office with a list of all medication allergies.

AIKEN PHYSICAL MEDICINE

Patient Missed Appointment Policy

DEFINITIONS:

- POLICY- a way of managing affairs so as to achieve some purpose.
- APPOINTMENT- a meeting with someone at a certain time and place.
- MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. Your Treatment Program consists of specific series of treatment(s) given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

Keep in mind our office hours. They are as follows:

Monday-Thursday 9:00am-12:00 pm, 2:00pm-5:00pm

If we did not insist that you meet all your appointments, we would be doing you a disservice and *we do care* about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

- Meet all of your appointments. Arrange the activities in your life so that this can occur.
- If you become ill, we still want you to come in, because treatments will help you recover.
- If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
- With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance to any appointment changes.
- All cancelled or missed appointments must be rescheduled and made up within one week.
- There is a $5.00 service charge for no call/no show appointments.
- There is also a $20.00 charge for missing an appointment with one of the doctors.

I have read and I understand and agree to follow the above policy.

Name:_____

Signature:_____

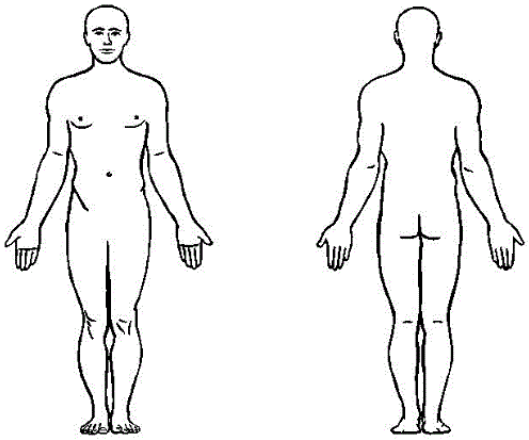
Date:_____

AIKEN PHYSICAL MEDICINE

PAIN QUESTIONAIRE

1. Why are you here today? _____

2. Indicate on the drawings below where you have pain/symptoms:



(Circle the best answer to the following questions)

3. Is your problem today caused by? Accident Trauma Other: _____

4. How often do you experience your symptoms?
Constantly Frequently Occasionally Intermittently

5. How would you describe the type of pain?

Sharp	Dull	Diffuse	Electric
Burning	Shooting	Stiff	Numb
Tingly	Stabbing	Other: _____	

6. How are your symptoms changing with time?
Getting Worse Staying the Same Getting Better

7. Using a scale from 0-10 (10 being the worst pain), how would rate your problem?
0 1 2 3 4 5 6 7 8 9 10

8. How much has the problem interfered with your work?
Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?_____

10. How long have you had this problem?_____

11. How do you think your problem began?_____

12. Does your pain prevent you from performing your Activities of Daily Living (ADL's)? YES NO

13. How would you rate your overall health? Excellent Very Good Good Fair Poor

14. What type of exercise do you do? Strenuous Moderate Light

15. Is there anything else pertinent to your visit today?_____

AIKEN PHYSICAL MEDICINE

CONSENT TO CARE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases 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.

We will attempt to identify and diagnose any ailments you may have that may be corrected through primary care, physical medicine, chiropractic care, physical therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I agree to settle any claim or dispute I may have 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 have read and understand the foregoing. I have read and I accept the terms above and understand them fully. I hereby give consent to Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam or any treatment if I so choose.

Please *initial* below:

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

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the office manager or case manager, about my concerns

_____ I acknowledge that HealthFirst sends appointment reminders via text and/or email. I can opt out of receiving text message/email reminders at any time.

_____ _____ ____/____/_____

Patient's Signature Print Name Date

FOR MINORS:

I, _____ being the parent or legal guardian of _____, have read and
(Print Guardian Name) (Print Minor's Name)
fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

_____ _____

(PARENT OR GUARDIAN SIGNATURE) (DATE)

AIKEN PHYSICAL MEDICINE

FINANCIAL POLICY

1. All patients are on a cash basis until our staff can verify all insurance coverage(s). Your insurance will be verified promptly and will be reviewed with you if applicable.
2. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
3. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
4. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
5. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
6. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
7. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information to my insurance company necessary to process any claims.
8. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
9. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
10. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.
11. PATIENT COOPERATION and NO GUARANTEE OF RESULTS: It is illegal and highly unethical for any doctor to guarantee results for any health care condition. However, we can speak of our experience and the success rate our office has had. We assure you that we as an office will do everything in our power to ensure you have a favorable outcome. In order to get the best results, please follow the visit frequency laid out in your care plan along with all healthcare provider recommendations. Patient recognizes this agreement is not a guarantee of results and deals solely with the services to be rendered and the fees to be paid for the care as provided. The patient's payment obligation is not contingent upon the outcome of care.
12.TEAM APPROACH: Our staff consists of doctors with a variety of specialties, so if need be, multiple doctors may be working on your individual case. All doctors in our office hold an active license. You could be treated by any or all of them.
13. If you are not completely satisfied with your experience in our office for any reason, you may opt out of treatment at any time. If that situation should arise, you will be refunded within 90 days of cancellation for any services that were not rendered minus any other outstanding charges on your account. Written notice must be given in order for the cancellation process to begin. Balances for rendered services are due in-full upon cancellation. 90 days is required to process a refund in order to give ample time for all insurance and laboratory billing to be processed and received. The refund shall equal the amount prepaid less any and all sums due for the services actually performed and/or any additional charges incurred by the patient such as products, labs, or supplementation.
14. I hereby assign directly to Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/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 Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and 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 and/or legal action to obtain (or protect) benefits and/or payments that are due (or have been previously paid) to either Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions myself, and/or my family members as a result of services rendered by Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Aiken Physical Medicine, LLC dba HealthFirst Integrated Healthcare Solutions. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.
15.SUBSEQUENT INJURIES: The care the patient is to receive under this care plan has been determined based upon the patient's present condition. If a new injury or condition arises during the course of treatment provided for in this care plan, the current care will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. Notify the office immediately if you have any type of accident whether work, auto, or home related.
I have read and fully understand the financial and office policy and agree to abide by these terms.

_____	_____	_____/_____/_____
Patient's Signature or Responsible Party	Printed Name	Date

AIKEN PHYSICAL MEDICINE

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ Last Name:_____

Email Address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email Phone Text Message

If you would prefer phone: (Please choose one) □ **phone call** □ **text message**

DOB: __/__/____

ALL QUESTIONS IN THIS BOX ARE FOR INFORMATIONAL PURPOSES ONLY
ALL QUESTIONS IN THIS BOX ARE OPTIONAL

Gender (Circle one): OPTIONAL
Male Female

Ethnicity (Circle one): OPTIONAL
American Indian Alaska Native Asian Black or African American
White (Caucasian) Native Hawaiian Pacific Islander

Ethnicity (Circle one): OPTIONAL
Hispanic or Latino Not Hispanic or Latino **Preferred Language:** _____

AIKEN PHYSICAL MEDICINE

This Office is HIPPA Compliant

HIPPA Compliance Information Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.
Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years.

This form is a "friendly" version. A more complete text will be printed and given to you upon request.
What this is all about: specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S Department of Health and Human Services, www.hhs.gov

We have adopted the following policies:
Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures within the office for the handling of charts patient records, PHI and other documents or information.
It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of change to office policy and new technology that you might find valuable or informative.
The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the Doctor.
Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
We agree to provide patients with their records in accordance with state and federal laws.
We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____Date_____
do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA Compliance Information Form and subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.