

INTEGRATIVE PHYSICAL MEDICINE OF DAYTON LLC. PATIENT INTAKE

GENERAL INFORMATION

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Marital Status: S M D W
Drivers License Number and State issued _____ State _____
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders? Yes No If yes, who is your cell phone provider? _____
How were you referred to our office? By an attorney By a doctor By a patient Someone from our office Internet search
 By your health insurance Drive-by Other; Please specify: _____

ACCIDENT INFORMATION

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other Date of Accident _____
Has the accident been reported? Yes No To Whom? _____ Claim Number _____

HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.* _____
Policy # _____ Group # _____
Insured's Name if different than yours _____ Insured's SS# ____ / ____ / ____
Relationship to Insured _____ Insured's Birth date ____ / ____ / ____ Employer _____

SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.* _____
Policy # _____ Group # _____
Insured's Name if different than yours _____ Insured's SS# ____ / ____ / ____
Relationship to Insured _____ Insured's Birth date ____ / ____ / ____ Employer _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor _____ Date _____

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt | _____ |

Are you currently pregnant? Yes No

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (Be sure to include dosage and frequency) _____

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

Please list any supplements you are currently taking (vitamins, minerals, herbs) _____

Are you currently on any blood thinners -- (aspirin regimen included)? Yes No List Type _____

Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.

Please CHECK if you have any of the following:

- A pacemaker Suffer from blood clots Knee/ hip replacement Local or systemic infection Egg allergy
 Corticosteroid or Local Anesthetic Allergy Additional allergies (please list) _____

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

- Heart Disease _____ Diabetes _____ Other _____
 Cancer _____ Arthritis _____ Other _____

Do you exercise?: Yes No How often?: 1X 2X 3X 4X 5X per week Other: _____

Which activities: Running Jogging Weight Training Cycling Yoga Pilates Swimming Other _____

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

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Energy Drinks _____ cups/day Cigarettes _____ packs/day

I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature _____ Date _____

Doctor Reviewed Signature _____ Date _____

Doctor Updated Signature _____ Date _____

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT
(CONSENT TO USE PHI)**

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Integrative Physical Medicine of Dayton or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below, I give my permission to use and disclose my health information
as stated in the notice of privacy practices.***

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

Insurance Company Payment(s) Policy

I _____, have been advised that the doctors and therapists at Integrative Physical Medicine of Dayton will bill my insurance company directly for my treatment. I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my treatment, and I understand that this money is intended to pay the above mentioned companies and physicians.

Accordingly, it is hereby understood and agreed to again that I have no right, implied or otherwise to said funds as they do not belong to me, and or the insured party and are intended to pay for my medical care and procedure(s) performed with my informed consent.

Furthermore, in the event I receive a check or checks from the responsible insurance company as payment for my treatment/procedure(s) or the insured's procedure(s), I will immediately or within forty eight hours contact the appropriate party (the office or the billing department) about the check and return these funds to the appropriate party(ies). I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Integrative Physical Medicine of Dayton with the collection of any funds.

In the event that a check or multiple checks are made payable to me or the insured and is received by Integrative Physical Medicine of Dayton or its physicians, I hereby grant the facility and above provider(s) the express permission and limited power of attorney solely and exclusively for the purpose of endorsing said check(s), so that I do not need to return to the facility with the express intent to endorse the funds to the facility / provider(s).

If either party defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other party employs the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of initiation of court proceedings, there in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this Lease shall be in the state courts in Montgomery County.

Patient/Guardian Signature

Date

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date

Provider: Integrative Physical Medicine of Dayton, LLC

2015 Cardiovascular Exam and Screening Questionnaire

Name (Please Print): _____ Date: _____

Gender: M / F Age: _____

Blood Pressure: _____ Pedal pulse equal bilaterally : Right: _____ Left: _____

Extremity Radicular Symptoms and negative NCV/EMG or region: Yes: _____ No: _____

Exophthalmus: Yes _____ Abdominal Aorta larger than 2c.m. Yes: _____

Please check the appropriate response.

	YES	NO
1. Do you have a family history of cardiovascular disease (heart) or strokes?	_____	_____
2. Do you have high blood pressure or high cholesterol?	_____	_____
3. Do you smoke or have you smoked in the past?	_____	_____
4. Do you have a stressful lifestyle?	_____	_____
5. Do you take birth control pills "females only" ?	_____	_____
6. Do you or any family member suffer from or have a family history of diabetes?	_____	_____
7. Do you experience headache symptoms?	_____	_____
8. Do you experience from dizziness or light-headedness?	_____	_____
9. Do you experience tinnitus (ringing of the ears)	_____	_____
10. Do you experience depression?	_____	_____
11. Have you gained or lost weight for no apparent reason?	_____	_____
12. Have you experienced hair loss or change in texture?	_____	_____
13. Have you been sleeping more or less than usual?	_____	_____
14. Do you have pain or fatigue in your legs, buttocks or calves after activity?	_____	_____
15. Do your legs, ankles, arms or hands swell during the day?	_____	_____
16. Do you have fatigue/weakness in your arms/hands?	_____	_____

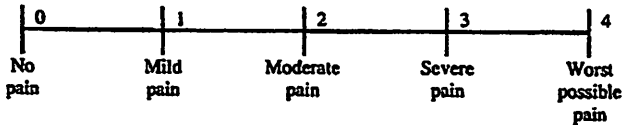
Patient's Name _____ Acct # _____

Functional Rating Index

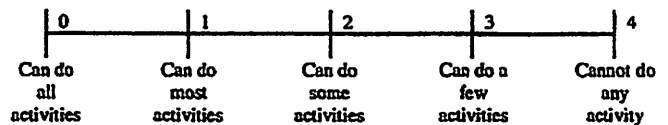
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

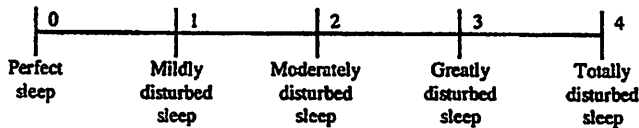
1. Pain Intensity



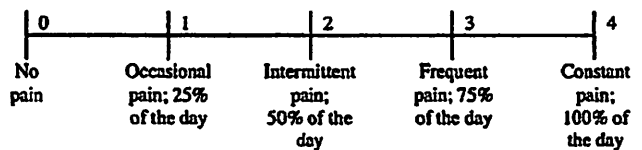
6. Recreation



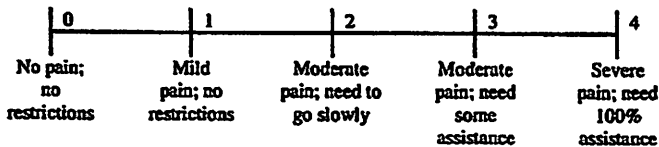
2. Sleeping



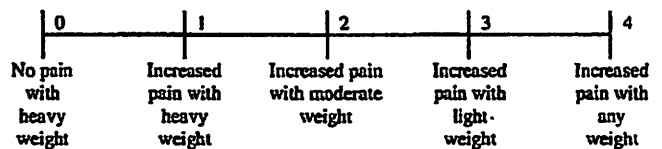
7. Frequency of Pain



3. Personal Care (washing, dressing, etc.)



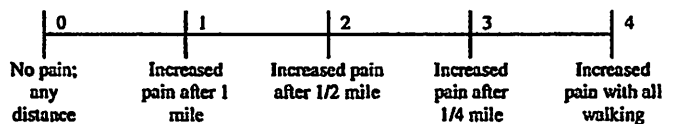
8. Lifting



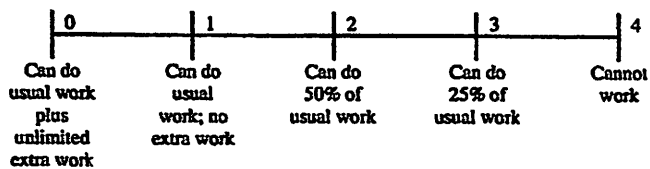
4. Travelling (driving, etc.)



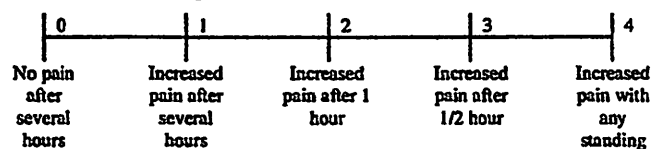
9. Walking



5. Work



10. Standing



Patient's Signature

Date

Office Use Only

Clinical Diagnosis Codes: _____

Total Score: _____ / 40

Doctor's Signature and Date: _____