Office Use Only

Pt#_____DOB: _____

Elite Healthcare
Physical Medicine

PATIENT APPLICATION FORM

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance. We look forward to serving you.

AUTHORIZATION OF CARE

Patient Name:_____ DOB:_____

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, 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. 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 these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). 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 not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Name (Print)	Patient's Signature	Date
Minor's Name (Print)	Guardian's Signature *(Authoring Care for Minor)*	Date

EMERGENCY CONTACT

Name:_____Relationship:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Elite Healthcare Physical Medicine, LLC. and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant_____(Initials)

_____
Patient's Name (Print)

_____ _____
Patient/Guardian Signature Date

MEDICAL RECORDS RELEASE FORM

In order to provide the best care possible for you, we may share your medical records with your family doctor to let them know the progress you are making with our office.

I, give Elite Healthcare Physical Medicine, LLC permission to share any and all medical records with my family doctor.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may revoke this authorization at any time by notifying the office. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Patient/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIC (HIPPA)

We understand that health information about you and your health is personal and we are committed to protecting your health information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

_____ _____
Patient/Guardian Signature Date

LIFETIME AUTHORIZATION ASSIGNMENT OF BENEFITS AND INSURANCE REALEASE

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize Elite Healthcare Physical Medicine, LLC to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Elite Healthcare Physical Medicine, LLC I hereby authorize Elite Healthcare Physical Medicine, LLC to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Staff Member Name (Print)	Staff Member Signature	Date

ASSIGNMENT OF BENEFITS for Medicare Patients Only

I request that payment of authorized Medicare benefits be made to me or on my behalf to Elite Healthcare Physical Medicine, LLC for treatment or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services for me to release it to the Center for Medicare/Medicaid Services and it's agency. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

Item(s) Provided: _____

_____

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Staff Member Name (Print)	Staff Member Signature	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:

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

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

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

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 allergies _____

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 should be avoided if patients have certain conditions. Please answer the following:

Do you have a pacemaker? ☐Yes ☐No Do you suffer from blood clots? ☐Yes ☐No Do you have knee/hip replacement? ☐Yes ☐No

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: _____

What 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 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 _____

CARDIOVASCULAR EXAM AND SCREENING QUESTIONNAIRE

Patient Name (Print):_____ Date: _____

Age: _____ Gender: M F Blood Pressure: _____ Pulse: _____

Please check the appropriate response.	**YES**	**NO**
1. Are you over the age of 45?	_____	_____
2. Do you suffer from headaches?	_____	_____
3. Do you have a family history of cardiovascular disease (heart) or strokes?	_____	_____
4. Do you have high blood pressure or high cholesterol?	_____	_____
5. Do you suffer from dizziness or light-headedness?	_____	_____
6. Do you smoke or have you smoked in the past?	_____	_____
7. Have you ever experienced tingling or numbness in your arms or legs?	_____	_____
8. Do you bruise easily?	_____	_____
9. Do you get tired easily or feel fatigued after common physical activity?	_____	_____
10. Do you have a stressful lifestyle?	_____	_____
11. Do you have pain in your legs after walking?	_____	_____
12. Do your legs, ankles, or hands swell during the day?	_____	_____
13. Do you take medication for high blood pressure or cholesterol?	_____	_____
14. Do you take birth control pills?	_____	_____
15. Do you have varicose veins?	_____	_____
16. Do you have vision problems (ie. temporary loss of vision, blind spots, floaters)?	_____	_____
17. Do you suffer from diabetes?	_____	_____
18. Do you have any swollen or stiff joints?	_____	_____