# Foundation Sport & Spine
# New Patient Intake

**Date:**_____

**Patient Name:**_____ **Age:**_____ **DOB:**_____

**Address:**_____**City:**_____**State:**_____ **Zip:**_____

**Email Address:**_____**Home Ph.#:**_____

**Cell Phone#:**_____**Subscribe to Email list for announcements/info? (Yes / No)**

**Occupation:**_____**Employer:**_____**Full /Part Time?:**_____

**Name of Spouse:**_____**Spouse's Occupation:**_____**Employer:**_____

**How many children?**_____

**EMERGENCY CONTACT:**_____**Relationship:**_____**Ph #:**_____

**Insurance Provider:**_____ **Policy#:**_____**Group#:**_____

**Name of Policy Holder:**_____ **Relationship to Policy Holder:**_____

**Policy Holder's DOB:**_____**Group Name(if applicable):**_____

**Family Medical Doctor:**_____**Office Ph.#:**_____

When doctors/trainers work together, you receive the best care. Do we have your permission to contact your medical physician, athletic trainer/coach (if applicable and necessary), regarding your care at this office?

(circle one) **YES** **NO**

**How did you hear about us? (circle one):**

**Existing Patient** **Google Search** **Yelp** **Website** **Coach** **High School** **Other (please specify)**

**Name of Person who referred you (if applicable):**_____

# Foundation Sport & Spine
# Patient History Form (1 of 2)

**History of Present Illness:**

**Chief Complaint/Purpose of this appointment:**_____

**Date symptoms appeared or accident occurred:**_____ **Due to (circle):** Sport Work Auto Other

**Briefly Describe:** _____

**Have you ever had the same or similar condition?:**_____ **If yes, when?:**_____

**Please Describe:**_____

**Date of Last Physical Exam:**_____ **Days of Work/Sport missed:**_____

**Have you seen other Physicians/Therapists? for this condition?**_____

**Past Medical History:**

**Please check if you now, or ever, have experienced the following (H-history of, P-presently having)**

**Constitutional:**
____Cancer
____Allergies
____Fever or Chills
____ Weight Loss or Gain
____Night Sweats
____Fatigue
____Insomnia or sleep changes
____Other:_____

**Cardiovascular:**
____Heart Disease
____High Cholesterol/Triglycerides
____High/Low Blood Pressure
____Stroke
____Rheumatic Fever
____Chest Pain
____Irregular/Rapid Heartbeat
____Fainting/Lightheadedness
____Ankle Swelling
____Varicose Veins
____Other:_____

**Pulmonary:**
____Asthma
____COPD
____Tuberculosis (TB)
____Pneumonia
____Difficulty Breathing
____Shortness of Breath
____Wheezing
____Chronic Cough/Phlegm
____Coughing up blood
____Other:_____

**Endocrine:**
____Diabetes I / II (circle one)
____Thyroid Disease
____Heat or Cold Intolerance
____Increased Thirst
____ Other:_____

**Gastrointestinal:**
____Appendicitis
____Jaundice/Hepatitis/Cirrhosis
____Ulcers
____Gallbladder Disease
____Colon Polyps
____Hemorrhoids
____Poor Appetite
____Abdominal Pain
____Black or bloody stool
____Frequent bloating or gas
____Frequent nausea or vomiting
____Frequent diarrhea or constipation
____Difficult Swallowing
____Other:_____

**Neurological/Psychological:**
____Epilepsy/Seizures
____Headaches
____Weakness
____Numbness/tingling
____Dizziness
____Arm/Leg Pain
____Tremor or twitching
____Depression/Anxiety
____Other:_____

**Musculoskeletal:**
____Fracture/Dislocation
____Sprain/Strain
____Arthritis
____Scoliosis/Spinal curve
____Neck Pain
____Upper back pain
____Low back pain
____Swollen/Painful Joint(s)
____TMJ/TM Joint pain
____Other:_____

**Genitourinary**
____Urinary Infection
____Kidney stones/disease
____Sexual difficulties
____Frequent urination
____Painful urination
____Bloody/discolored urine
____Incontinence
____STD/STI
____Other:_____

**Eye, Ear, Nose, Throat:**
____Glaucoma
____Poor Vision
____Pain in eye
____Deafness
____Sinusitis
____Dental Problems
____Hoarseness
____Nosebleeds
____Other:_____

**PATIENT SIGNATURE:**_____ **DATE:**_____

# Foundation Sport & Spine
# Patient History Form (2 of 2)

**Past Medical History (continued):**

**Please check if you now, or ever, have experienced the following (H-history of, P-presently having)**

**Blood/Lymph:**
___Anemia
___Bleeding Disorder
___Enlarged/Swollen lymph nodes
___Other:_____

**Skin:**
___Changing mole/skin tag
___Concern about skin lesion
___Itching or rash
___Pressure ulcers
___Fungal infection
___Other:_____

**Childhood Diseases:**
___Measles
___Mumps
___Chicken Pox
___Rheumatic Fever
___Other

**Male Specific:**
___Prostate Disease
___Testicular Pain or swelling
___Impotence/Erectile Dysfunction
___Difficulty Urinating
___Urgency
___Weak/abnormal stream
___Other:_____

**Female Specific:**
Date last normal menstrual period began:
_____
___Live Births
___Miscarriage or abortion
___Painful periods
___Irregular or heavy periods
___Breast Pain/palpable lump
___Hot flashes
___Other:_____

**FAMILY HISTORY:**
___Cancer
If yes, type and whom?
_____
___Stroke
___High blood pressure
___Heart disease
___Diabetes I / II (circle)
___Thyroid Disease
___Kidney Disease
___Neurological Disease
___Psychiatric Disease
___Other:_____

**Please list any history of trauma, injuries, major illnesses, falls, auto accidents or surgeries:**

_____

**Have you been treated by a physician in the past year? If yes, for what?**_____

_____

**Have you ever been treated by a chiropractor? (list experience)**_____

_____

**What medications are you currently taking?**_____

_____

**What vitamins/supplements are you currently taking?**_____

_____

**Do you have any allergies?**_____

**Social History:**

Do you drink alcoholic beverages?_____If so, how many per week?_____

Do you/did you use smoke or tobacco products?_____If so, how much?_____

Do you exercise? Please describe:_____

Describe your dietary habits:_____

**PATIENT SIGNATURE:**_____**DATE:**_____

# Foundation Sport & Spine
# Chiropractic Informed Consent Form (1 of 2)

**Chiropractic Care:** The practice of chiropractic medicine utilizes many standard examination and testing procedures that are common among the medical field, such as physical examination, orthopedic, neurological testing, palpation, soft tissue correction, and rehabilitative procedures. What sets chiropractic healthcare apart is that it seeks to restore health through natural means without the use of medicine or surgery. Chiropractic care seeks to remove offensive stresses to the nervous system and thereby allow the body to use its own inherent recuperative powers to heal itself.

**Analysis:** The goal of the chiropractic care in our clinic is to find and address the offending tissues or any functional articular lesion (sometimes known as a Vertebral Subluxation Complex or VSC). As those are corrected, we then seek to find the faulty muscle and movement patterns, help the body re-program and reinforce proper movement patterns, and then to add stability, strength, and power to the whole system. Overall, the success of this process of healing and re-injury prevention depends on the patient's environment, underlying causes, physical, and spinal condition. Because of this complexity, no doctor can promise specific results within a given time frame.

**Diagnosis:** Doctors of Chiropractic medicine are highly trained in diagnosis in general, and chiropractic diagnosis in particular. However, they are not internal medicine specialists. Every patient should be aware and mindful of his or her own symptoms, and should seek out other opinions if he or she has any concern as to the nature of his or her total condition. You should always let your chiropractor know of these concerns also, so they may express an opinion as to whether or not you should seek out other medical care, and may even be able to recommend and refer you to another physician/specialist. Still, it is your responsibility to make the final decision.

**Treatment/Therapy:** The primary therapy used in chiropractic treatment will likely be spinal manipulative therapy or adjustments. Adjustments are usually performed by hand, but are sometimes performed using hand-guided instruments. A chiropractic adjustment is a quick, short, and precise movement applied to a specific point of contact on a joint to create motion where it is lacking, thereby addressing and correcting the osteo-ligamentous portion of the VSC, and restoring proper joint function. The adjustment may or may not create an audible "pop" or "click," similar to the sensation experienced when you "crack" your knuckles. You will also likely experience a sense of movement in the area(s) adjusted.

**Neuromuscular Activation:** Because so much of what happens in our body physically is a direct result of what is happening in the nervous system, one of the main treatment techniques, known as P-DTR, or Proprioceptive Deep Tendon Reflex technique aims at correcting "software" issues that are affecting "hardware" issues in your body. At some points, stirring up the nervous system may require a deep stimulation or unwinding of a muscle fiber or tissue. This technique, along with other soft tissue techniques, such as IASTM (Instrument-assisted Soft Tissue Mobilization), and ART (Active Release Technique) may produce slight bruising, and likely muscle soreness comparable to that of an intense workout the day before, but usually resolves within 24-72 hours post treatment.

**Results:** As stated above, the purpose of chiropractic care is to promote and restore the body's ability to heal itself through reduction of the VSC, faulty movement patterns, instability, and muscle imbalance/weakness. Since there are so many variables in outcome, it is difficult to predict the time schedule of efficacy of chiropractic treatment. Sometimes the response is nearly instantaneous and phenomenal. Most of the time the response is gradual, but quite satisfactory to the patient. At times, the results are slower or less than expected. You may not respond in the same way or as quickly to treatment for the same condition as another patient. Many medical care failures respond incredibly well to chiropractic care, yet there are some conditions that cannot be helped through chiropractic, and medical treatment is warranted and effective. Both have taken great strides in alleviating pain and controlling progression of disease.

**Probability and Nature of Inherent Risks of Chiropractic Adjustment and Treatment:** As with any health care procedure, there are certain complications that may arise during chiropractic manipulative therapy. Chiropractic adjustments are usually beneficial and rarely cause a problem. Complications, though rare, include but are not limited to fractures, disc injuries, dislocations, cervical cord compression (myelopathy), or separations. Occasionally, after manipulation and therapy, you may experience muscle strain, new or increased radicular tingling, numbness or pain. It is not uncommon for you to experience soreness or stiffness following the first few days of treatment.
Some types of manipulation to the neck (cervical spine adjusting) have been associated with injuries to arteries in the neck, or other causes leading or contributing to rare but serious complications including stroke, paralysis, or neurological dysfunction.

**PATIENT SIGNATURE:**_____**DATE:**_____

# Foundation Sport & Spine
# Chiropractic Informed Consent Form (2 of 2)

The relationship between cervical manipulation and strokes is the subject of tremendous disagreement among the medical community. However, the incidence of strokes is extremely rare, and it is estimated that they occur between one in one million and one in five million cervical adjustments. Some types of manipulation to the low back (lumbar spine adjusting) have been associated with injuries to the distal end of the spinal cord, or other causes leading or contributing to a rare but serious complication that if not addressed as a surgical emergency, could lead to prolonged or permanent loss of bowel and bladder function, and a saddle-like numbness/tingling/pain. It is your responsibility to report any of these rare symptoms to your chiropractic physician immediately, so that immediate action may be taken to prevent long-term complications.

**Availability and Nature of Other Treatment Options:** Other treatments for your condition may include self-administered, over-the-counter analgesics and rest; medical care and prescription drugs (such as muscle relaxers and anti-inflammatory/pain-killers), hospitalization, and/or surgery. If you choose any of the other treatment options for your condition, you should be aware that there are risks and benefits of such options and you should discuss those with your primary medical physician, should you pursue any of those treatment methods.

**Risks and Dangers of Remaining Untreated:** If you choose to remain untreated, that decision may result in persistent pain, increasing pain, increased loss of function, formation of further adhesions in joints, between muscles and muscles, between nerves and muscles. The sum of any or all of these potential results of remaining untreated may contribute to a pain reaction, which may further reduce your mobility and may cause a worsening of your condition. Additionally, if you decide to remain untreated, this may complicate or make future treatment difficult and less effective, the longer treatment is postponed.

**DO NOT SIGN BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.**
**PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.**

**I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustments and the related treatments. I have discussed options, goals, and risks of various treatment options, and alternative treatment options with Dr. Porcher, and have had my questions answered to my satisfaction. By signing below I state that it is in my best interest to undergo the treatment recommended. I have been informed of the benefits, risks, and alternatives, and I hereby give my consent to chiropractic treatment.**

| | |
|---|---|
| **Patient's Name (please print)** | **Doctor's Name** |
| **Patient's Signature** | **Doctor's Signature** |
| **Signature of Parent/Guardian (if patient is under 18 years of age)** | **Date** |
| **Date** | |

# Foundation Sport & Spine
# Financial Agreement (1 of 2)

At Foundation Sport & Spine, Ltd., it is our passion and drive to direct our attention to getting you back to health and peak performance. Let us first clarify the financial aspects of your care so we can focus on your health. Outlined below is our Financial Agreement:

**Third Party Payers (Insurance Pay Option):**
If you have health insurance, were injured at work, in an automobile accident, or some other personal injury, we expect payment of deductibles, co-payments, and co-insurance at the time of service (of each visit). As our patient you understand your responsibilities as follows:

- I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
- I am responsible to make co-payments and co-insurance payments at the time of my office visit.
- I am responsible for all non-covered services. I understand that the office will do its best to inform me of any services that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until **after** the claim is submitted and processed, and there is no guarantee of payment by my insurance carrier.
- I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- I understand that the office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid to them. Any claim unpaid because I did not supply the office my health insurance information in a timely fashion is my responsibility and I agree to cover those unpaid expenses.

**Self-Pay Option:**
Some individuals may not have health insurance plans that are in our network, such as HMO plans, plans that do not cover the types of treatments rendered at our clinic, or other situations. In these cases, the patient may opt to choose the self-pay option. Self-payers are eligible to receive a 10% discount at the time of service. Greater discounts are available when paying for a treatment/care plan, recommended by your doctor, as a single payment.

**Individual Consideration:**
If you are experiencing real, financial hardship associated with receiving care in our office, please understand that we will not refuse any patient care due to their financial situation. We will, however, come to an agreement for payment of services.

**Billing:**
Payment is due at the time of service. Any outstanding balances will be billed monthly and balances

**PATIENT SIGNATURE:**_____**DATE:**_____

# Foundation Sport & Spine
# Financial Agreement (2 of 2)

beyond 45 days overdue may be subject to a billing fee of 5.0% per month, and may require the involvement of a collections agency. A returned check from our financial institution is subject to a returned check fee of $35.00 per returned check.

**Missed Appointments:**
I understand that if I have an appointment scheduled and fail to cancel at least twenty-four hours in advance, during the business hours of the office, that I will be charged a $25 fee for the doctor's time. I understand that insurance companies do not pay for this fee and the responsibility to pay is mine.

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY:** I have read and understood the above statements in Foundation Sport & Spine, Ltd.'s financial agreement, and have had all of my questions answered to my satisfaction. Therefore, I hereby authorize payment directly to the provider. I understand that my insurance policy is a contract between myself and my insurance company and that I am ultimately responsible for knowing my insurance coverage and benefits. I understand that I am ultimately responsible for all fees and charges, regardless of my insurance coverage and agree to pay any deductible, co-payment, co-insurance, or any uncovered service. I also understand I may not be allowed to schedule new appointments if I have a past-due balance owed to the provider.

**AUTHORIZATION TO RELEASE INFORMATION (Insurance Only)**: I understand that the provider will file my insurance claim for me only as a courtesy. I hereby authorize the provider to release any information require to process my claim.

**I am choosing to pay using (please select one option below):**

**____Health Insurance Plan as described above**

**____Self-Pay Option as described above**

**I have read and understand the foregoing information/policy:**

**Patient's Signature:**_____ **Date:**_____

**Signature of Parent/Guardian Authorizing Care:**_____ **Date:**_____

**Signature of Witness:**_____ **Date:**_____

# Foundation Sport & Spine
# Consent for Purposes of Treatment, Payment, and Healthcare Operations

I,_____ (print name) consent to Foundation Sport & Spine, Ltd.'s ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but are not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and the disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Name of Patient/Personal Representative Description of Personal Rep.'s Authority

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I,_____(print name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Foundation Sport & Spine Center, which describes the Practice's policies and procedures regarding the use and disclosure of my Protected Health Information created, received, or maintained by the Practice.

**Patient's Signature:_____ Date: _____**

***For Office Use Only—If Notice Is Not Provided to Patient***

*Foundation Sport & Spine Center has made good-faith effort to obtain an acknowledgement of _____(patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, Foundation Sport & Spine Center has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):*

*___Patient Unavailable*
*___Patient Physically Unable*
*___Patient Unwilling*

*In an effort to obtain the patient's acknowledgement, Foundation Sport & Spine Center has attempted to provide the patient with a Notice of Privacy Policy Practices in the following manner (check all that apply): Personal Mail Phone Follow-Up*

Signature:_____Date:_____Print Name of Physician:_____

_____ Foundation Sport & Spine, Ltd.