

Patient Name: _____ Date: _____



Application for Patient Care

First Name: _____ M.I.: _____ Last Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

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

Last 4 of SS#: - _____ Age: _____ DOB: ____ / ____ / ____ Male / Female

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ___ Yes ___ No

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone

Occupation: _____ Employer: _____

Type of Tasks Performed/Common Movements: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently pregnant? No Yes If yes, how many weeks? _____

Have you had an auto accident? (X if applies): 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Had a recent fall/other accident? (X if applies) : 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Have You Ever Received Physical Therapy Chiropractic Care or Pain Management ? Last Visit: _____

How Did You Hear About This Office? Referred By: _____

Existing Patient Walk-In/Drive-By Groupon Living Social Internet Insurance Company

Ad: _____ Community Event: _____ Other: _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release

Method of payment for today's charges: ___ Cash ___ Check ___ Visa / MC

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, OVATION CHIROPRACTIC & WELLNESS 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 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.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care.)

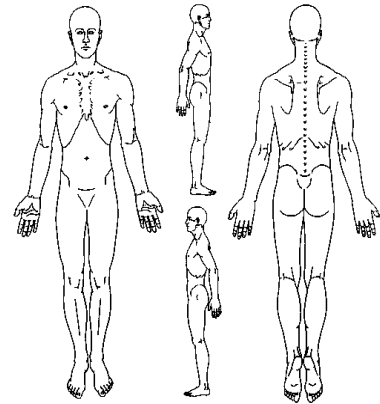
SIGNATURE (X) _____ DATE _____

Patient Name: _____ Date: _____

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Foot Trouble |



Most severe complaint: _____

What word best describes this complaint? Sharp Dull Achy Throbbing Numb Shooting other: _____

How often do you feel this complaint? Constant Daily Weekly "Off and On"

How long have you had this complaint? _____ Days Weeks Months Years

Is it getting better, worse or staying the same? Better Worse Same

What makes it better, if anything? _____ What makes it worse, if anything? _____

On a scale of 0-10 rate your discomfort. (0 = no pain, 10 = excruciating) 0 1 2 3 4 5 6 7 8 9 10

2nd most severe complaint: _____

What word best describes this complaint? Sharp Dull Achy Throbbing Numb Shooting other: _____

How often do you feel this complaint? Constant Daily Weekly "Off and On"

How long have you had this complaint? _____ Days Weeks Months Years

Is it getting better, worse or staying the same? Better Worse Same

What makes it better, if anything? _____ What makes it worse, if anything? _____

On a scale of 0-10 rate your discomfort. (0 = no pain, 10 = excruciating) 0 1 2 3 4 5 6 7 8 9 10

Impact of your symptoms: Circle to ways these issues are affecting your life:

- job children sex marriage household hobbies finances sports exercise walking standing bowels
 urinary fatigue loss of sleep moody poor attitude loss of productivity

Improving these issues in my life would improve my quality of life by: 10-20% 30-40% 50-60% 70-80% 90% 100%

Patient Name: _____ Date: _____

PATIENT HEALTH HISTORY continued.... Please check if you have ever had any of the following:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> TMJ Pain |
| <input type="checkbox"/> Blood Pressure:
High or Low (circle) | <input type="checkbox"/> Fractures | <input type="checkbox"/> Hormone/Gland
Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Gout | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Menopausal Prob. | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid
Arthritis | <input type="checkbox"/> Vaginal Infections |
| | | | | <input type="checkbox"/> Other: _____ |

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

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

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

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

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

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Other _____ |

Do you exercise: 5-7x/week 3-4x/week 1-2x/week Occasionally None
 Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor
 Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes ____ pks/day

NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

- | | | | |
|---|--------|--------------------------------------|--------|
| 1. Weakness, numbness or burning in your shoulder, arms or hands? | NO YES | 8. Cold Hands/Feet? | NO YES |
| 2. Do your hands or arms fall asleep regularly? | NO YES | 9. Have you had an MRI? | NO YES |
| 3. Reduced feeling (sensation) or swelling in your hands or arms? | NO YES | | |
| 4. Loss of handgrip strength? | NO YES | If yes to MRI, When? Who ordered it? | |
| 5. Weakness, numbness or burning in your buttocks, legs or feet? | NO YES | What was it ordered for? _____ | |
| 6. Do your legs or feet fall asleep regularly? | NO YES | _____ | |
| 7. Reduced feeling (sensation) or swelling in your legs, feet? | NO YES | _____ | |

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 & accurate information during my exam.

Signature (X) _____

Date _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The 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 have read and I accept the terms above and understand them fully. I hereby give consent to the clinic 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 and/or x-rays or any treatment if I so choose.

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.

Office Visit Policy: *Ovation Center has the right to charge a fee of \$35.00 for appointments not cancelled within 24 hours of scheduled time or not showing for scheduled appointment and payment will be due on next visit. If patients show up for appointments late we may re-schedule or full treatment time may not be given. For Chiropractic and Decompression Patients: If visit is made up within the week or following week, fee will be waived.*

Massage Therapy for Minors Policy: *If the patient is a minor child, under the age of 18, a parent or guardian must be in the treatment room for the entire treatment time.*

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

FOR MINORS: I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient OVATION CHIROPRACTIC & WELLNESS CENTER we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Sheri Beck. If you would like further information about our privacy policies and practices please contact: Sheri Beck.

This notice is effective as of December 1, 2012. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print)

Signature

Date

Patient Name: _____ Date: _____



Ovation Chiropractic & Wellness Center: Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19 The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Ovation Chiropractic & Wellness Center (“OCWC”) has put in place preventative measures to reduce the spread of COVID-19; however, the OCWC cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, coming into OCWC could increase your risk and your child(ren)’s risk of contracting COVID-19. By signing this agreement, we acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that our child(ren) and we may be exposed to or infected by COVID-19 by choosing OCWC for our care and that such exposure or infection may result in personal injury, illness, permanent disability, and death. We understand that the risk of becoming exposed to or infected by COVID-19 at OCWC may result from the actions, omissions, or negligence of myself and others, including, but not limited to, OCWC employees and other patients. We voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to our child(ren) or ourselves (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense of any kind, that we or our child(ren) may experience or incur in connection with our child(ren)’s attendance at the OCWC or participation in chiropractic and/or massage services. On our behalf and on behalf of our children, we hereby release, covenant not to sue, discharge, and hold harmless OCWC, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. We understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the OCWC, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during or after receiving care at OCWC. We further affirm and agree that we will act in good faith and keep ourselves or any family members home from OCWC if we are experiencing any symptoms of illness. OCWC follows all mandated guidelines to place safety measures at OCWC. We reserve the right to change or modify protocols at our discretion to ensure our patients and staff are safe while still providing the best experience at OCWC during COVID-19. We understand that failure to follow OCWC’s rules & regulations, including those outlined in the written compliance plan may result in removal from the practice.

Patient Name Date

Patient Signature

Family Members:

