Health Edge Group, LLC

Application For Patient Care

PATIENT INFORMATION

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

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 #:_____

ACCIDENTS

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

Had a recent fall/other accident? (**X that applies**): ☐ 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?_____

REFERRALS

How Did You Hear About This Office? ☐ Existing Patient: _____

☐ Walk-In/Drive-By/saw sign ☐ Radio: _____

☐Natural Awakenings ☐ Internet, which site: _____

☐Women's Mag ☐ Ad:_____

☐TV which channel:_____ ☐ Community Event: _____

☐Post&Courier ☐ Other: _____

INSURANCE

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, Health Edge Group, LLC, 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.

SIGNATURE (X)_____**DATE** _____

Health Edge Group, LLC

PATIENT HEALTH HISTORY

PLEASE CHECK TO INDICATE IF YOU HAVE HAD ANY OF THESE SYMPTOMS IN THE LAST THREE MONTHS:

Is there a family history of: ❑ Heart Disease ❑ Diabetes ❑ Cancer ❑ Arthritis
❑ Other
:_____

MEDICALHISTORY:

❑ Allergy Shots
❑ Anemia
❑ Anorexia
❑ Arthritis
❑ Bleeding Disorders
❑ Blood Pressure: High
❑ Blood Pressure: Low
❑ Breast Lump
❑ Broken Bones
❑ Bulimia
❑ Cancer
❑ Chemical Dependency
❑Defibrillator
❑ Diabetes
❑ Epilepsy
❑ Fibromyalgia
❑ Fractures
❑ Gout
❑ Heart Attack
❑ Heart Problems
❑ Hepatitis
❑ Herniated Disc
❑ Hernia
❑Hormone/Gland Problems
❑ Migraines
❑ Multiple Sclerosis
❑ Osteoporosis
❑ Pacemaker
❑ Pinched Nerve
❑ Prosthesis: _____
❑ Rheumatoid Arthritis
❑ Rheumatic Fever
❑ Stroke
❑ TMJ Pain
❑ Tuberculosis
❑Tumors/Growths
❑ Ulcers
❑ STD/AIDS/HIV
❑ Other_____
❑N/A (medical history)

Have you had:NCV Test: ❑No ❑Yes Date:_____ MRI: ❑No ❑Yes Date:_____ Allergy test: ❑No ❑Yes Date:_____
Other: _____
Please list any surgeries and/or hospitalizations you have had **(type & date):**_____
_____
_____

What is your **current** intake of: Caffeine ___cups/day Alcohol ___drinks/week Cigarettes ____packs/day

Do you have a **history of**: ❑Cigarette use ___packs/day❑ Alcohol__drinks/wk❑Drug use ____type/quantity

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:_____

X-ray Questionnaire: For men only: I understand that my consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze my condition. I authorize the performance of any diagnostic x-rays necessary.

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 _____

ALLERGY FOOD AND CHEMICAL SENSITIVITY SURVEY

PLEASE CHECK TO INDICATE IF YOU HAVE HAD ANY OF THESE SYMPTOMS (MILD, MODERATE, OR SEVERE) IN THE LAST 6 MONTHS:

Y N

Neurological

___ ___ Migraines
___ ___ Headaches
___ ___ Slurring of speech
___ ___ Ringing in Ear
_____ Dizziness
_____ Paralysis

Eye/Ear/Nose/Throat

___ ___ Altered taste/smell
___ ___ Night Blindness
___ ___ Sore Throat
___ ___ Nose bleeds
___ ___ Ear Infections
___ ___ Sinus infections
___ ___ Hay fever

Cardiovascular/Endocrine

___ ___ Chest pain
___ ___ Palpitations-racing heart beat
___ ___ Swelling in hands/feet
_____ Anemia
_____ Hypoglycemia
_____ Hyperglycemia
_____ Thyroid/low cold feet

Respiratory

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

GI

___ ___ Stomach Pains or Cramping
___ ___ Constipation
___ ___ Reflux or Heartburn
___ ___ Bloating
___ ___ Gas
___ ___ Nausea or Vomiting
___ ___ Diarrhea
_____ 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

What are you allergic to:

_____
_____
_____
_____
_____

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

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 test, 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 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.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.

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 Health Edge Group, LLC 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.

Please initial below:

_____ I acknowledge that it is the policy of HEG to leave reminder messages on my answering machine 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 Health Edge Group 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.

_____ _____

(SIGNATURE) (DATE)

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 Health Edge Group, LLC 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 Health Edge Group, LLC 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 Health Edge Group, LLC, myself, and/or my family members as a result of services rendered by Health Edge Group, LLC, 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 Health Edge Group, LLC is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Health Edge Group, LLC 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 Health Edge Group, LLC.* 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 Print Name Date

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 / Mail

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

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?*(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency(i.e5mg / once a day, etc.)

Do you have any medication allergies?□ NKDA			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **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 chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____