Patient Name: _____ Date: _____

OVATION
CENTER OF INTEGRATIVE MEDICINE

Application for Patient Care

First Name: _____ M.I.: _____ Last Name: _____ Date:_____
Address: _____ City: _____
State: _____ Zip:_____ Email: _____
Phone: Cell: _____-_____-_____ Home: _____-_____-_____ Work: _____-_____-_____
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 CENTER OF INTEGRATIVE MEDICINE AND/OR 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.)

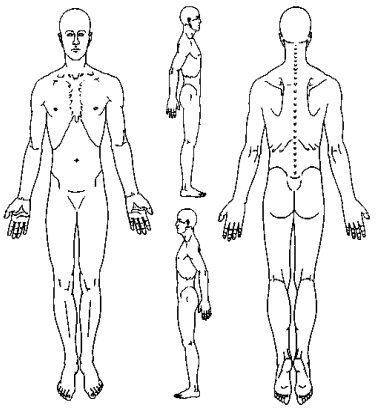
SIGNATURE (X) _____ **DATE** _____

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:

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

□ ADD/ADHD
□ Aids/HIV
□ Alcoholism
□ Allergy Shots
□ Anemia
□ Angina
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma/Wheezing
□ Bad Breath/Taste
□ **Bleeding Disorders**
□ Blood Pressure: High or Low (circle)
□ Breast Lump
□ Broken Bones
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Colon Trouble
□ Contacts/Glasses
□ Depression
□ Diabetes
□ Dry Skin
□ Ear Infections
□ Epilepsy
□ Fibromyalgia
□ Fractures
□ Gall Bladder
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heartburn
□ Heart Attack
□ Heart Problems
□ Hemorrhoids
□ Hepatitis
□ Hernia
□ Herniated Disc
□ Herpes
□ High Cholesterol
□ Hormone/Gland Problems
□ Insomnia
□ **Kidney Problems**
□ **Liver Disease**
□ Measles
□ Menopausal Prob.
□ Migraines
□ Miscarriage
□ Mononucleosis
□ Mouth Sores or Bleeding Gums
□ Multiple Sclerosis
□ Mumps
□ Nosebleeds
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Pinched Nerve
□ Pneumonia
□ Polio
□ Prostate Problems
□ Prosthesis
□ Psychiatric Care
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Scarlet Fever
□ Sexual Difficulty
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ TMJ Pain
□ Tonsillitis
□ Tremors
□ 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 and all medications you are currently taking: _____

_____

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

Are you currently taking blood thinners? Yes No

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

_____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Mildew
___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander
___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

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

□ Heart Disease_____ □ Diabetes _____
□ Cancer _____ □ Arthritis _____ □ 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

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_____

Patient Name: _____ 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)

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	_____	

Patient Name: _____ 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 CENTER OF INTEGRATIVE MEDICINE AND 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-discloser 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: Michelle Bradley. If you would like further information about our privacy policies and practices please contact: Michelle Bradley.

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*