PRO SPORT
EMPOWERING HUMAN PERFORMANCE

ORTHOPEDIC SURGERY
PHYSICAL THERAPY
SPORTS CHIROPRACTIC
MASSAGE THERAPY

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1 PATIENT INFORMATION

Patient Name _____ Date _____
Last First (Legal) (Middle Initial) Nickname

Date of Birth: ____ / ___ / _____ Age: _____ ❑ M ❑ F Social Security #_____

❑ Married ❑ Widowed ❑ Single ❑ Divorced ❑ Partnered ❑ Minor

Mailing Address: _____City: _____State: _____Zip: _____

Cell: _____ Home Phone: _____ E-Mail: _____

Occupation: _____ Employer: _____ Business Phone: _____

Spouse's Name: _____ Date of Birth: ___ / ___ / _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other

Whom may we thank for referring you: _____ Who is your primary care physician? _____

Is today's visit due to a: Work Related Injury? ❑ Auto Accident? ❑ Date Of Injury: _____

Have you submitted an L&I "Report of Accident" Form? ❑ No ❑ Yes, Claim Number: _____

(If yes to either questions above, please check with the Front Desk, additional information is needed)

2 INSURANCE INFORMATION

Do you have health insurance? ❑ No ❑ Yes, Company Name:_____

Are you the primary subscriber? ❑ Yes ❑ No, Subscribers Name:_____

Are you covered by more than one insurance company? ❑ No ❑ Yes, Company Name:_____

Have you provided us with a copy of your insurance card? ❑ Yes ❑ No

(If no to above question, please provide front desk staff with copies of all insurance cards that you would like to have billed)

3 ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Washington. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

Patient or Responsible Party Signature: _____ ***Date:*** _____

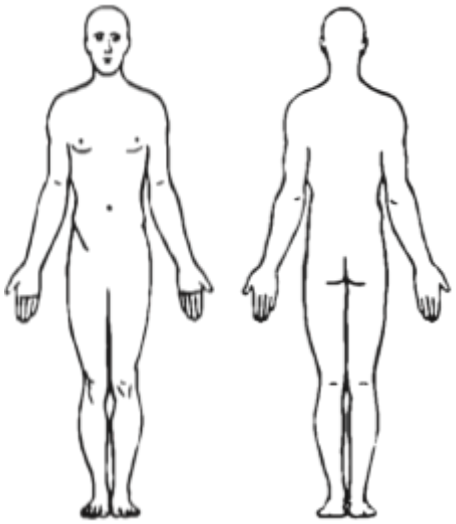
4 PATIENT CONDITION

Reason for visit and goals for seeking treatment? _____

When and how did this injury occur? _____

Have you ever had a metal implant? ❑ No ❑ Yes, Location? _____

Are you pregnant? ❑ No ❑ Yes, Due Date _____



Mark with an "**X**" on the diagram where you have pain/numbness/tingling:

Rate the severity of your pain on a scale from **1** *(least)* to **10** *(severe)*: _____

Type of pain: ❑ Sharp ❑ dull ❑ throbbing ❑ Numbness ❑ aching ❑ shooting ❑ burning

❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is your condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Is it constant or does it come and go? _____

How long have your symptoms persisted for? ❑ __Hour(s) ❑ ____Day(s) ❑ ___Weeks(s) ❑ _Month(s)
❑ _____Year(s)

Have you had this condition/injury before? ❑ No ❑ Yes, When? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

5 HEALTH HISTORY

Please list the Doctor(s) or Clinic(s) you have seen for your condition: _____

Please list the medications/vitamins/minerals you are currently taking: _____

Are you allergic to any Medications? ❑ No ❑ Yes, Which? _____

Please mark indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dep
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Press
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine/ Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheum Arthritis
- ☐ Scarlet Fever
- ☐ S.T.D
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infect
- ☐ Whooping Cough
- ☐ _____
- ☐ _____
- ☐ _____

6 We take this subject very seriously as this can make a difference between responding to treatment or not. We require a 24 hour notice in the event of a cancellation. **There is a $75-100 charge for a cancellation or no-show** without proper notice. For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY**.

INFORMED CONSENT:

Medical doctors, Chiropractic Doctors, Physical Therapists, and Licensed Massage Therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, physical therapy, and massage therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, and home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of medical treatment. Any questions I have had regarding these procedures have been answered to my satisfaction ***PRIOR TO MY SIGNING THIS CONSENT FORM****. I have made my decision voluntarily and freely.*

_____ **Signature of Patient** **Date** _____

_____ **Signature of Parent/Guardian** **Date** _____
(If a minor)

_____ **Signature of Witness** **Date** _____
(If signing on someone's behalf)

STATEMENT OF FINANCIAL LIABILITY:

I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges **AT THE TIME OF SERVICE**.

I understand that unless otherwise indicated below, I hereby request and authorize Pro Sport Clinic and their providers to bill my insurance policy/policies for all services provided to me. I authorize payment to Pro Sport Clinic and their providers for all such services. I acknowledge that the fees charged by Pro Sport Clinic and their providers are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, Pro Sport Clinic and their providers will not enter into any dispute between you and your insurance company. When you begin treatment with Pro Sport, our billing department will call your insurance company to verify that you do have valid insurance coverage. **However, that verification is only a confirmation of a valid policy and not a guarantee of coverage.**

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES:

☐ By checking the box to the left, I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by Pro Sport Clinic/Pro Sport Providers to be "non-covered" and I am fully responsible for payment of all such "non-covered" services.

ALTERNATE BILLING / PAYMENT INSTRUCTIONS:

☐ By checking the box to the left, I hereby direct Pro Sport Clinic and their providers to **NOT** bill my insurance company for services provided to me and instead I agree to pay all fees for services furnished to me. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility.

PERMISSION TO RELEASE MEDICAL INFORMATION (HIPAA ACKNOWLEDGEMENT):

I authorize Pro Sport Clinic and their providers to release information from my medical record or from the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to Pro Sport Clinic and their providers until written notice revoking it is provided. I release Pro Sport Clinic and their providers of all responsibility or liability for loss of confidentiality through access and/or copies of records release, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's Name: _____

Patient or Legal Guardian's Signature: _____ **Date:** _____

I authorize the below people have access to, make changes, or request information regarding my care here at Pro Sport Clinic in accordance with HIPAA guidelines:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____