Health First Rehab, INC

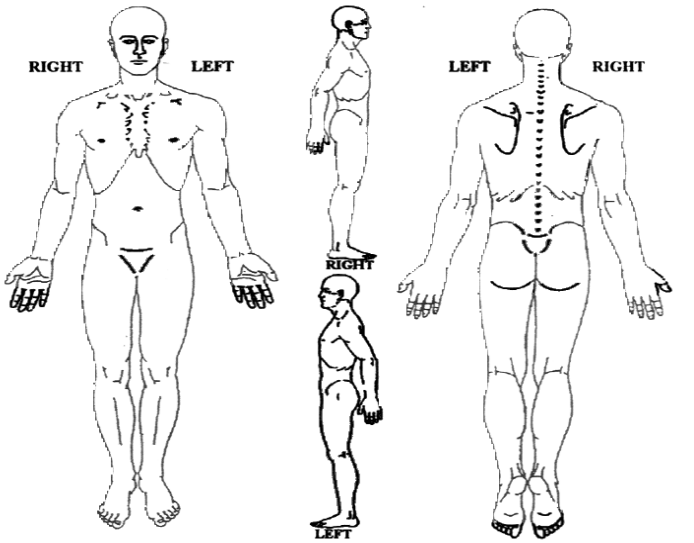
PATIENT PAIN FORM

Patient: _____ **Date of Birth:** _____ **Today's Date:** _____

Date of Injury (if applicable): _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



Problem List: **(This Section for Office Use Only)**

MOI:

1. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

2. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

_____
Patient Signature

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Sharp/Stabbing ☐ Dull, Achy ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning ☐ Other:

Symptoms radiate/refer to my: ☐ head ☐ shoulders ☐ arms ☐ Hips ☐ buttocks ☐ Legs

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity ☐ Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath	☐ Nausea /Vomiting	☐ Difficulty sleeping
☐ Difficulty breathing	☐ Fevers / Chills	☐ Difficulty concentrating
☐ Pain with coughing	☐ Light-headed, dizziness	☐ Memory problems
☐ Bowel/bladder changes	☐ Visual changes	☐ Mood swings, irritability
☐ Urinary incontinence	☐ Hearing changes	☐ Loss of appetite/Weight loss
☐ Blood in stool	☐ "Foggy/Hazy" feeling	☐ Fatigue
☐ Other symptoms:		

Office Policies - Health First Rehab, Inc.

Informed Consent to Treatment

By signing below, I consent to the services being rendered during this visit by Dr. Joshua Lindauer, DC or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for Dr. Lindauer, DC. I am informed that there are some rare but potential risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have been informed of possible alternative therapies. No guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$10.00*** per visit for this service. **_____Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will to file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require a 24 hour notice for appointment cancellations. Health First Rehab, Inc. reserves the right to charge ***$50.00*** for the missed visit if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____Initial

I have read the Health First Rehab, Inc. office policies and will honor them:

_____	_____	_____
Print Name	**Patient Signature**	**Date**

Patient Name: _____

NON INSURED TIME OF SERVICE CASH PAYMENT/PATIENT RESPONSIBLE

All payments are due at time of service unless other arrangements have been made in advance.

Service(s): Check those that apply	***(F)* Cost:**
☐ Initial evaluation/Treatment	☐ $90
☐ Office Visit/Treatment	☐ $60 per visit
☐ Electrodes/reusable pads	☐ $6 per set of 4 pads
☐ Other:	☐ $____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

OPTIONS: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I **want** the services listed above. I am responsible for any/all outstanding balances incurred during my treatment with Health First Rehab, INC

❑ **OPTION 2.** I **don't want** the services listed above listed above.

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

Patient Information

Date:_____

Name: DOB:

Address:

Town: State: Zip:

Home Phone: Cell #:

E-mail address:

Social Security # - -

Marital Status:

Emergency Contact:

Relation: Phone:

Occupation:

Primary Care MD:

Permission to send treatment notes: Yes NO