Ord Sports Chiropractic & Wellness
232 S 16th St
Ord, NE 68862
P: (308) 728-9986
ordsportschiro@gmail.com

PATIENT INFORMATION **DATE:** _____/_____/_____

FIRST NAME _____ MIDDLE NAME _____ LAST NAME_____

PREFERRED NAME_____DATE OF BIRTH_____ SOCIAL SECURITY #_____-_____-_____

ADDRESS_____CITY_____ STATE_____ ZIP CODE_____

SEX: ☐MALE ☐FEMALE **MARITAL STATUS**: ☐MARRIED ☐SINGLE ☐OTHER _____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

EMAIL_____

SPOUSE NAME_____ NUMBER OF CHILDREN/AGES_____

EMERGENCY CONTACT PHONE_____RELATIONSHIP_____ NAME_____

REFERRAL INFORMATION

REFERRED BY: ☐NEWSPAPER ☐RADIO ☐SOCIAL MEDIA ☐FRIEND/RELATIVE_____

EMPLOYMENT INFORMATION

EMPLOYED: ☐FULL TIME ☐PART TIME ☐UNEMPLOYED ☐STUDENT ☐HOMEMAKER ☐SELF ☐RETIRED

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

WORK DUTIES_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

POLICY #_____GROUP #_____

INSURED'S NAME_____ INSURED'S DATE OF BIRTH_____

INSURED EMPLOYER_____ RELATION TO INSURED_____

SECONDAY INSURANCE COMPANY_____

POLICY # _____GROUP #_____

INSURED'S NAME_____ INSURED'S DATE OF BIRTH_____

INSURED EMPLOYER_____ RELATION TO INSURED_____

IS TODAYS VISIT DUE TO A WORK RELATED INJURY (Workers Comp): ☐ YES ☐ NO

IS TODAYS VISIT DUE TO AN AUTO ACCIDENT: ☐ YES ☐ NO

SOCIAL HISTORY

ALCOHOL: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

HOW MANY DRINKS PER WEEK_____

DIET FOOD PRODUCTS: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

OVER THE COUNTER PAIN KILLERS: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

HOMEMADE FOOD: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

SOFT DRINKS: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

CAFFEINE: ☐YES ☐NO AMOUNT PER DAY_____

ADEQUATE WATER: ☐YES ☐NO AMOUNT PER DAY_____

RECREATIONAL DRUGS: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

EXERCISE: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

PROCESSED FOOD: ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

TOBACCO: ☐SMOKELESS ☐SMOKING ☐DAILY ☐WEEKLY ☐OCCASIONALLY ☐NEVER

WHAT /HOW MANY PER DAY_____

ADEQUATE SLEEP: ☐YES ☐NO EXPLAIN: _____

STRESSFUL JOB: ☐YES ☐NO EXPLAIN: _____

STRESSFUL FAMILY LIFE: ☐YES ☐NO EXPLAIN: _____

HEALTHY DIET: ☐YES ☐NO EXPLAIN: _____

HEALTH HISTORY

IN GENERAL, WOULD YOU SAY YOUR HEALTH IS:

☐EXCELLENT ☐VERY GOOD ☐GOOD ☐FAIR ☐POOR

LAST PHYSICAL EXAM: _____PRIMARY PHYSICIAN_____

PREVIOUS CHIROPRACTIC CARE: ☐YES ☐NO CHIROPRACTOR'S NAME_____

MEDICATIONS/ SUPPLEMENTS CURRENTLY TAKING WITH DOSES: _____

_____

_____

ARE YOU CURRENTLY PREGNANT: ☐YES ☐NO

HAVE YOU **EVER** HAD A STROKE: ☐YES ☐NO

HAVE YOU **EVER** HAD BLOOD CLOTS: ☐YES ☐NO

HAVE YOU RECENTLY EXPERIENCED:

☐DIZZINESS ☐UNEXPLAINED FATIGUE ☐WEIGHT LOSS ☐BLOOD LOSS

IF YES, EXPLAIN: _____

MAJOR ILLNESSES: ☐YES ☐NO EXPLAIN: _____

HOSPITALIZATIONS: ☐YES ☐NO EXPLAIN: _____

AUTO ACCIDENTS: ☐YES ☐NO EXPLAIN: _____

HEALTH CONDITIONS: ☐YES ☐NO EXPLAIN: _____

SURGERIES:

DATE	SURGERY	DATE	SURGERY

BROKEN BONES: ☐YES ☐NO EXPLAIN: _____

SPRAINS/STRAINS: ☐YES ☐NO EXPLAIN: _____

STRUCK UNCONSCIOUS: ☐YES ☐NO EXPLAIN: _____

EATING DISORDERS: ☐YES ☐NO EXPLAIN: _____

FAMILY HISTORY: _____

PERSONAL HEALTH CHECKLIST:

☐ASTHMA	☐ALCOHOLISM	☐ANEMIA	☐ALLERGIES
☐ARTHRITIS	☐ARTERIOSCLEROSIS	☐BACK PAIN	☐BLOOD DISORDER
☐BREAST LUMP	☐CHRONIC BRONCHITIS	☐BRUISE EASILY	☐CANCER
☐CHEST PAIN	☐COLD EXTREMITIES	☐CONSTIPATION	☐CRAMPS
☐DEPRESSION	☐DIABETES	☐DIGESTION PROBLEMS	☐DIZZINESS
☐EXCESSIVE MENSTRUATION	☐EYE PAIN/ DIFFICULTIES	☐FREQUENT URINATION	☐FATIGUE
☐HEADACHES	☐HIGH BLOOD PRESSURE	☐HOT FLASHES	☐HEART PROBLEMS
☐EAR, NOSE, THROAT	☐IRREGULAR HEARTBEAT	☐IRREGULAR PERIODS	☐KIDNEY INFECTIONS
☐KIDNEY STONES	☐MEMORY LOSS	☐LOSS OF BALANCE	☐LOSS OF SMELL
☐LOSS OF TASTE	☐NOSEBLEEDS	☐PACEMAKER	☐POLIO
☐POOR POSTURE	☐PROSTATE PROBLEMS	☐SCIATICA	☐STROKE
☐SPINAL CURVATURES	☐SHORTNESS OF BREATH	☐SINUS INFECTIONS	☐INSOMNIA
☐SWOLLEN JOINTS	☐THROID DYSFUNCTION	☐TUBERCULOSIS	☐ULCERS
☐VARICOSE VEINS	☐VENEREAL DISEASE	☐JOINTS/ BONES	☐OSTEOPOROSIS
☐LUNG PROBLEMS	☐MUSCLE PROBLEMS	☐NERVE PROBLEMS	☐BOWEL/INTESTINAL

☐OTHER:_____

CHIEF COMPLAINT INFORMATION

CHIEF COMPLAINT_____

ONSET OF SYMPTOMS/ DATE OF OCCURANCE_____

WHERE INJURY OCCURRED: ☐AUTO ☐WORK ☐THIRD-PARTY ☐OTHER INJURY DATE: _____

HAVE YOU HAD THIS PAIN BEFORE: ☐YES ☐NO

WAS THE ONSET: ☐GRADUAL ☐SUDDEN

SINCE ITS' ONSET, HAS IT GOTTEN: ☐ WORSE ☐BETTER ☐SAME

DESCRIBE WHAT CAUSED THE PAIN: _____

FREQUENCY OF PAIN: ☐ALWAYS ☐HOURLY ☐DAILY ☐OCCASIONALLY

INTERFERE W/ ACTVITIES: ☐YES ☐NO AFFECTED SLEEEP: ☐YES ☐NO MISSED WORK: ☐YES ☐NO

AFFECTED APPETITE: ☐YES ☐NO REDUCED WORK: ☐YES ☐NO

AGGRAVATES CONDITION _____

IMPROVES CONDITION _____

HAVE YOU DETECTED ANY POSSIBLE RELATIONSHIP OF YOUR CURRENT COMPLAIN WITH ANY OF THE FOLLOWING:

☐MUSCLE WEAKNESS ☐BOWEL/BLADDER PROBLEMS ☐DIGESTION

☐CARDIAC/RESPIRATORY ☐OTHER _____

RECEIVED TREATMENT: ☐YES ☐NO EXPLAIN_____

X-RAYS, MRI, or CTs TAKEN? ☐YES ☐NO EXPLAIN_____

SAME CONDITION BEFORE: ☐YES ☐NO DATE_____ PRACTITIONER_____

HAVE YOU TRIED ANY SELF-TREATMENT OR TAKEN ANY MEDICATION (OVER THE COUNTER OR PRESCRIPTION)?

☐YES ☐NO IF YES, EXPLAIN_____

PAIN CHART

Please mark areas of pain using the codes below. Write them on the pictures to the right.

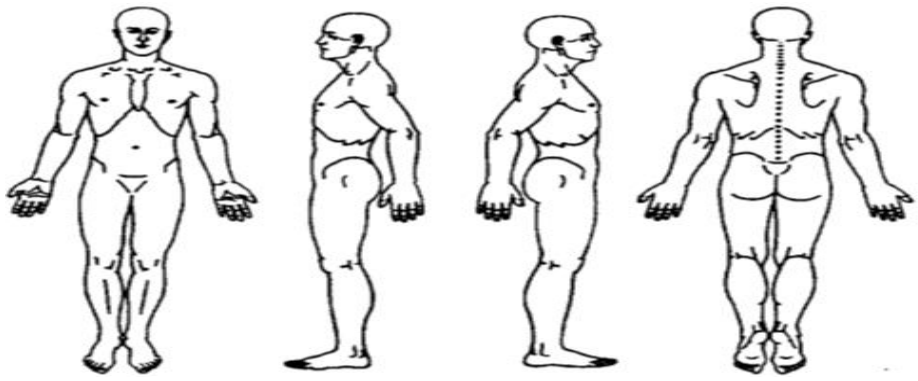
BBB for Burning

DDD for Dull/Ache

NNN for Numbness/Tingling

TTT for Throbbing

SSS for Stabbing/Sharp



(Front) (Left) (Right) (Back)

SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, I personally owe to you.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Ord Sports Chiropractic and Wellness is paid in full.

Patient Signature_____ Date_____/_____/_____

CONTINUE

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical 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 that 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 disease, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Current medical research suggests there is no increased risk of stroke from spinal manipulation. However, some poorly constructed studies in the past suggested that there is a very slight incidence (one in about 10 million) that chiropractic manipulation can contribute to stroke.

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, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to 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, 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 outcome, 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 chiropractic 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.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent or Guardian (if a minor) **Date**

Ord Sports Chiropractic and Wellness

Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment**. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly**. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

- **It is our policy to collect at time of service**. Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges**. Payment is due within 30 days of receipt of the bill**.
- **In the event a bill is disputed, you must notify us within 30 days**. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 12% per annum**. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks

- It is our policy to collect **$25.00** for checks that are returned to us. This is to cover any fees that apply from the transaction

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Ashley Weeks.

HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.
- I authorize this office to allow family and friends looking for me to be given information as to my arrival or departure of the premises, and or leave a message for me if I have not arrived or am in with the doctor.

Designation of Authorized Representative

I do hereby designate Ord Sports Chiropractic and Wellness to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Ord Sports Chiropractic and Wellness. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

I do hereby authorize Ord Sports Chiropractic and Wellness to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Ord Sports Chiropractic and Wellness.

_____ _____

Signature of Patient or Parent or Guardian (if a minor) **Date**

Ord Sports Chiropractic & Wellness

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): E-mail / Text / None

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

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

CMS requires providers to report both race and ethnicity

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

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Are you allergic to any medications?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

For office use only

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