PATIENT INTAKE FORM

Please Print Clearly

Name:_____ Social Security #:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
E-mail (Please!) _____
Date of Birth:_____ Age:_____ [ ] Male [ ]Female
[ ]Married [ ]Widowed [ ]Single [ ]Separated [ ]Divorced [ ]Minor
Patient Employer/School:_____ Occupation:_____
Spouseôs Name:_____ Spouseôs Date of Birth:_____
Family Medical Doctor:_____ Phone:_____
How were you referred to this office?_____
Emergency Contact:_____ Phone:_____
(Name and Relation)

Please check any/all insurance coverage that may be applicable in this case:

[ ] Major Medical [ ] Workersô Compensation [ ] Medicare [ ] Auto Accident
[ ] Other:_____
Name of person responsible for the insurance account:_____
Relationship to Patient:_____
Insurance Company:_____

INJURY INFORMATION

Current Symptoms/Injury:_____
Was the injury a result of : [ ]Work [ ] Slip/Fall [ ] Car Accident [ ] Chronic [ ] Other
When did your symptoms appear? _____
Are your symptoms: [ ] Getting Better [ ] Getting Worse [ ] Staying about the same?
Have you previously seen any health care specialist for this condition? [ ] Yes [ ] No
Who did you see? _____
Are you currently working? [ ] Yes [ ] No If No, is that due to this injury? [ ] Yes [ ] No

MEDICAL HISTORY

Have you ever had the same/similar symptoms? [ ] No [ ] Yes If Yes, please explain:_____
_____
_____
_____
Prior treatment with: [ ] MD [ ] Chiropractor [ ] Physical Therapy [ ] Acupuncture [ ] Massage
Has any prior treatment helped? [ ] Yes [ ] No [ ] a little
Any prior surgeries? [ ] No [ ] Yes If yes, please describe:_____
_____
Please list any health conditions that you have or have had before (cancer, heart disease, diabetes, arthritis, etc.)_____
Have you ever been under the care of a Chiropractor? [ ] Yes [ ] No If Yes, for what?_____
_____
Please list all current medications (Prescription and non-Prescription):_____
_____

Patient Signature: **Date:**

CURRENT INJURY/SYMPTOMS

1. Please describe where the syptoms are located:

2. What percentage of time do you feel pain?
☐ **0-25%** ☐ **25-50%** ☐ **50-75%** ☐ **75-100%**

3. Where is your pain level today? (circle one)
(lowest) 1 2 3 4 5 6 7 8 9 10 **(highest)**

4. What activities/movements increase your pain levels?
_____
_____
_____

5. Type of pain:
[ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Cramps
[ ] Aching [ ] Shooting [ ] Burning [ ] Tingling [ ] Stiffness [ ] Swelling
[ ] Other _____

6. Do you have any weakness in your arms or legs? ☐ Yes ☐ No

7. Have you been told that your current injury requires surgery? ☐ Yes ☐ No

OTHER SYMPTOMS

Do you have ANY of the following symptoms?
[ ] **Pain worse at Night** [ ] **Unexplained Weight Loss** [ ] **Weakness in the Arms/legs**
[ ] **Recent Surgery (30 days)** [ ] **Loss of Bowel or Bladder Control**
[ ] **Urinary Discharge** [ ] **Loss of Sensation** [ ] **Fatigue/loss of Energy**
[ ] **Trouble with Balance/Coordination**

Does your condition interfere with; [ ] **Work** [ ] **Sleep** [ ] **Sports** [ ] **Recreation** [ ] **Normal Daily Routine**

Have you had any Prior imaging studies? [ ] **X-Ray** [ ] **MRI** [ ] **CT Scan** [ ] **Bone Scan**

Print Name:	
Patient Signature:	**Date:**

PRIVACY STATEMENT (HIPAA GUIDELINES)

Consent for Purposes of Treatment, Payment and Health Care Operations

Consent for Treatment: I, (print name)_____, am presenting myself for outpatient care at Pioneer Sports and Pain Center, including diagnostic procedures and medical/chiropractic treatment by authorized agents, employees of Pioneer Sports and Pain Center, and the medical staff (or their designees) as in their professional judgment may deem necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

I understand the diagnosis and treatment of me by Pioneer Sports and Pain Center may be conditioned upon my consent as evidence by my signature of this document.

I understand I have the right to request a restriction to protect my health information when used or disclosed to carry out treatment, payment or health care operations of the practice. Pioneer Sports and Pain Center is not required to agree to the restriction that I may request. However, if Pioneer Sports and Pain Center agrees to a restriction that I request the restriction is binding on Pioneer Sports and Pain Center . I have the right to revoke this consent, in writing, at any time , except to the extent that Pioneer Sports and Pain Center has taken action in reliance on the consent.

I understand I have the right to review Pioneer Sports and Pain Center's Notice of Privacy Practices prior to signing this document.

The Pioneer Sports and Pain Center Notice of Privacy Practices has been provided at 1619 N Linder Rd., Kuna, ID 83634 and on the Pioneer Sports and Pain Center website.

This Notice of Privacy Practices also describes my rights and the duties of Pioneer Sports and Pain Center with respect to my protected health information.

Pioneer Sports and Pain Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Pioneer Sports and Pain Center website, calling the office, requesting a revised copy to be sent in the mail, or asking for one at the time of my appointment.

Notice of Privacy Practices– Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Daily notes will be released to third parties for billing and legal purposes. You may see your record or get more information about it by contacting the Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and

Patient Signature:	**Date:**

Consent for Use of Testimonial

This signed consent confirms your agreement by which Pioneer Sports & Pain Center has the right to use your testimonials which includes the following: (1) your personal testimonial, whole or in part, regarding treatment, services received, products, customer service, or any other appropriate comments and (2) your first name, last initial, and city and state in which you live. You hereby agree as follows:

1. You hereby grant Pioneer Sports & Pain Center the right to use your testimonials.

2. The Testimonials may appear in connection with (1) the business website, www.PIONEERclinic.com, (2) publications for the business related to advertising, marketing, information and education, or any other publication Pioneer Sports & Pain Center may deem useful and appropriate, (3) all electronic and print media (i.e. CD-ROM, video, pamphlets, mailings, etc.).

3. You hereby agree that you are over the age of 18 years old.

4. You hereby release Pioneer Sports & Pain Center from any claims and expenses arising from the use of your Testimonial as herein specified.

By signing this Consent Form you are acknowledging your consent to the terms noted above.

Patient Signature:	**Date:**

OFFICE POLICIES

1. Please be on time for your appointment. Being late or making last minute cancellations will cause scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Please do not wear strong perfumes or colognes. We see many patients some of which may have allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment. There will be a missed appointment fee of $35.00 if your appointment is not cancelled 24 hours in advance.
4. Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will assist you with your well-behaved children.
5. We may schedule you for multiple appointments. This will help insure a convenient appointment time for you, as well as provide you with the highest level of care possible.
6. If you nee d to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your nest appointment accordingly.
7. Please notify your doctor of *any* changes in your health status, regardless of the significance.

FINANCIAL POLICIES

1. We accept the following forms of payment: Cash, personal checks, debit cards, Visa Master Card, American Express, Discover and Care Credit.
2. Payment is expected at the time of the visit.
3. We will bill your insurance company with information provided by you at the time of service.
4. The Patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
5. Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below authorizes assignment to this office for collection for benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.
6. The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.
7. Any account where no payment has been received for 60 days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. Idaho Statute Title 67-2358 allows us to add up to 33% of current account balance to accounts when turned over to our collection agency for fee recovery! NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence.
8. We do offer a **time of service discount** when services are paid in full at the time of the visit. This discounted amount will be passed on to your insurance company.
9. In some cases, we may have a contract with your insurance company governing how we handle your account, This contract may prevent us from offering your our time of service.
10. Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
11. Your insurance company determines benefits when they receive you billings. Any statements made by our staff regarding your coverage in no what guarantees that your care here will be covered by your insurance

Patient/Guardian Signature:	**Date:**
Witness:	**Date:**