



PATIENT NAME _____ DATE _____

Last

First

Social Security # _____ - _____ - _____ Date of Birth ____/____/____ SEX: M F

Address _____
City State/Zip

Secondary Address _____
City State/Zip

Primary Phone # (____) _____ Secondary Phone # (____) _____
Please circle: Cell or Home Please circle: Cell or Home

Email Address _____

Employer _____
Name Address /City/State/Zip Phone

Emergency Contact _____ Relationship to Patient _____ Phone _____

Referring Physician _____ Phone _____

Person Responsible for Payment _____ / _____
Name Relationship to Patient

Address _____
Street City State/Zip Phone

INSURANCE INFORMATION:

PRIMARY INSURANCE:

Policy/ID Number: _____ Group Number: _____

POLICY HOLDER: _____ Policy Holder Date of Birth ____/____/____

Relationship to Patient: Self Spouse Parent Guardian Other _____ Phone: _____

Policy Holder Address: _____
Street City State/Zip

SECONDARY INSURANCE:

Policy/ID Number: _____ Group Number: _____

POLICY HOLDER: _____ Policy Holder Date of Birth ____/____/____

Relationship to Patient: Self Spouse Parent Guardian Other _____ Phone: _____

Policy Holder Address: _____
Street City State/Zip

SIGNATURE _____ DATE _____

HOW DID YOU HEAR ABOUT US: REFERRING DOCTOR FAMILY / FRIEND INTERNET LOCATION OTHER

INITIAL PATIENT QUESTIONNAIRE

This questionnaire is designed to help us obtain necessary information about your health problems and activity level. Completing the form as completely as possible will help us to develop the most effective treatment program to meet your needs. If you have difficulties answering or understanding these questions, please ask for assistance.

NAME: _____ Date: _____

DOB/Age: _____ Sex: M F Height _____ Weight _____

What is your injury? _____

Date of injury/onset of symptoms? _____

What is the mechanism/cause of injury? _____

Have you had previous treatment for this condition? Y N

If yes, what type of treatment? _____

Was there surgery? Y N If so, what type of surgery? _____

Date of surgery: _____

Where is your pain located? _____

Please indicate all symptoms: ___ Ache/Dull pain ___ Burning ___ Numbness

___ Other: please explain: ___ Spasm/Cramp ___ Pins & Needles ___ Stabbing/Sharp Pain

_____ ___ Stiffness ___ Shooting Pain ___ No pain

Please circle the numbers that indicate your pain level in the following categories. **Zero** indicates **no pain** and **ten** indicates the **worst** your symptoms have been.

WORST: 0 1 2 3 4 5 6 7 8 9 10

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

BEST: 0 1 2 3 4 5 6 7 8 9 10

What increases your pain? _____

What activities, movements or treatments relieve your pain? _____

PAST MEDICAL HISTORY

Please check if you experience any of the following:

- | | | | |
|-------------------------------------|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis/Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Faintness | <input type="checkbox"/> Difficulty Controlling | <input type="checkbox"/> Osteoarthritis/ | <input type="checkbox"/> Lupus Erythematosis |
| | <input type="checkbox"/> Bowel or bladder | <input type="checkbox"/> Joint disease | |

Muscle Weakness/Where? _____ Numbness/Where? _____

Joint Pain/Where? _____ Swelling/Where? _____

Other _____

Current Medications Prescription/over the counter:

Have you undergone any special testing recently Y N

If so, which ones: XRAY MRI CAT SCAN BONE SCAN Dates: _____
EMG EKG STRESS TEST INJECTION _____

Please list all surgeries in the last 5 years? _____

WORK HISTORY

Current Work Status: Full-time Part-time Light Duty Not Working Unemployed

Where do you work? _____

What is your vocation/profession? _____

Briefly describe your tasks at work? _____

Are you currently off work? Y N

When did you stop working? _____ **When do you return to work?** _____



INSURANCE VERIFICATION
ACKNOWLEDGEMENT

Date: _____

I _____ understand that Continuum Wellness has
Patient/Guardian

contacted my insurance company, _____, in
Insurance Company

A good faith effort to obtain my benefit information including co pay, co-insurance and deductible portions that may be my obligation should insurance deem me responsible. However, Continuum has explained to Me and I am fully aware that this information obtained from the insurance company is by no means a guarantee of payment by my insurance and therefore agree to pay any unpaid portion that my insurance deems my responsibility.

CONTINUUM WELLNESS REPRESENTATIVE

PATIENT/GUARDIAN



Date : _____

Patient Name: _____ Med Rec # / Account# _____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

_____	_____	_____
Name of Authorized Individual	Relationship	Phone#
_____	_____	_____
Name of Authorized Individual	Relationship	Phone#

CONSENT FOR TREATMENT:

Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of the physician and therapist.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:

I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to provider for unpaid charges. I agree to pay provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:

I consent to allow provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:

Patients are encouraged to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on "hold" for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:

In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature: _____ Date: _____

Print Name: _____ (when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).

Signature of Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: Parent Medical Power of Attorney (attach documentation)

Other _____ (Explain and Attach Documentation)



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date : _____

Patient Name: _____ Med Rec # / Account# _____

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: _____ Date: _____

Print Name: _____ (when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).

Signature of Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: Parent Medical Power of Attorney (attach documentation)

Other _____ (Explain and Attach Documentation) _____

**(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT**

Patient Name: _____

Date: _____

The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

Patient refused to sign acknowledgement.

Patient was unable to sign the acknowledgement because:

Other reason (describe below):

Name of Employee Completing Form: _____

Signature: _____

Date: _____