Integrated Sports Therapy, PC
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Trainawaypain.com

PATIENT INFORMATION FORM

First Name:______________________ Middle Initial: _____ Last Name: ______________________________________

Address: ____ City: ___________________ State:_____ Zip Code: ________

Home Phone: ______________________ Work Phone _______________________ Cell Phone _____________________

Email address: ______________________________ Date of Birth:________________ Social Sec #: _ _ _- _ _ - _ _ _ _

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other ____________

Work Status: ☐ Employed ☐ Part-time student ☐ Full-time student ☐ Other _______________

Employer (if applicable) ___________________________________ Address __________________________________

City _______________________ State _____ Zip Code ___________

REFERRED BY: **_________________________________**

EMERGENCY INFORMATION:

Emergency Contact: ______________________________________ Relationship: _______________________

Emergency Contact Number(s): (H/W/C) (circle) _________________________ (H/W/C) (circle) ________________________

Emergency Contact Email: _________________________________

**INFORMED CONSENT WAIVER AND AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature, that I am aware that the IST practitioner is a licensed chiropractic physician and although rare, injury from treatment or manipulation may have affects that may include stroke, disc herniation and/or other injuries or complications.

Signature ____

Date____________________________

Signature of Parent or Guardian if patient is under 18: ____

Date___________________________

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION RELATED TO PATIENT:

I the undersigned, authorize the release of medical information to the ***EMERGENCY CONTACT*** named on this form:

Signature ____ Date____________________________

Signature of Parent or Guardian
if patient is under 18: ____Date______________________

****Appointment cancellations require 24-hour notice to avoid visit charge.***

INSURANCE INFORMATION

IST is an out-of-network provider for all insurance plans.

With your permission, we will contact your insurance company and confirm the details of your benefits for out-of-network providers. This includes co-insurance amounts, deductible requirements, coverage exclusions, coverage limitations and categories of patient care that are covered. We will inform you of the information that we obtain.

Insurance Company ___________________________

ID/Policy Number ___________________________

Do you have a Medical Flexible Spending Account? ☐ **Yes** ☐ **No**

Important: If you are not the policyholder, please provide the following policyholder information. IST will need this information in order to process insurance claims.

Insured's Name ___________________________ Insured's date of birth ___________________________

Insured's Telephone: (W/H/C) ______________________ Insured's Email: ________________________________
(circle)

Your relationship to the Policyholder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other ____________**

****Please notify us if you have a secondary insurance carrier.***

AUTHORIZATION

I authorize the ***release*** of any medical or other information necessary to process my claims. I also ***request*** payment of benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

____ ____________________________

Signature of patient or person acting on patient's behalf ***Date***

**** Please provide us with your insurance card. We will make a copy for our records.***

INTEGRATED SPORTS THERAPY FINANCIAL POLICY

The well being of our patients is our primary concern and our goal is to provide excellent care to everyone who seeks our services. Part of maintaining a good physician-patient relationship is advising you in advance of office policies related to our practice. Please read this page carefully and indicate your agreement by signing below. If you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please let the front desk know you are here and sign in. It is your responsibility to notify the office of any new insurance coverage.
2. **We require that all patients maintain a valid credit card on file with us. Any patient balances that are present after 30 days from the date of invoicing will be automatically billed on your credit card.**
3. You are responsible for any and all co-payments, deductibles and coinsurances not covered by your insurance.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. You are responsible for any balance on your account.
5. While we verify your insurance coverage as a courtesy, it is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. Payment for all IST services is the responsibility of the patient and is either due at the time of your visit or upon presentation of our invoice. As out-of-network medical providers, IST does not participate in any private or government sponsored insurance plans. We will, however, submit insurance claims for services provided to commercial insurance companies on our patients' behalf. Medicare patients are encouraged to seek reimbursement for these services directly from Medicare. We will provide Form 1490S (SC) – Patient's Request for Medical Payment, as well as all information related to treatment required by Medicare.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits (EOB), except for Anthem, which does not send IST any information related to patients' EOBs. Anthem patients will be billed immediately following their visit. Your remittance is due *within* 10 business days from the date of our invoice. **If we do not receive payment the balance will be placed on your credit card.** If your credit card is not valid, any balance over 60 days will be forwarded to a collection agency. Unpaid account balances that are more than thirty (30) days past due, shall accrue interest at the rate of eighteen (18%) percent per year on any and all past due amount. In the event that your account is sent out for collection, you will be liable for all reasonable attorney fees and expenses.
9. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
10. We require a 24-hour notice for cancelling any appointments. We reserve the right to assess a $50 charge for missed medical appointments if the time cannot be filled by another patient. Performance Enhancement patients will have the session charged against their package.
11. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name: ____

____ ______________________________

Name of Responsible Party Relationship

____ ______________________________

Signature of patient or person acting on patient's behalf (if minor) ***Date***

This signature will serve as credit card authorization signature for any remaining balances.

MEDICAL HISTORY

Please list any significant medical illnesses or diagnoses given to you by a physician. Check the box if you were hospitalized for the condition.

____ ☐

____ ☐

Age of mattress _________________________ ☐ Comfortable ☐ Uncomfortable

Are you wearing ☐ heel lifts ☐ soles lifts ☐ inner soles (orthotics)

SURGICAL HISTORY

Operation __________________________ Date ___________ Reason _________________________________

Operation __________________________ Date ___________ Reason _________________________________

Operation __________________________ Date ___________ Reason _________________________________

EXERCISE

Type ___________________________ Hours per day ________________ Days per week ______________

SITTING

Computer – hours per day _______________________ TV – hours per day ______________________________

CURRENT MEDICATIONS

Medication ________________ Dosage ________________ Frequency ____________________

Medication ________________ Dosage ________________ Frequency ____________________

Medication ________________ Dosage ________________ Frequency ____________________

Medication ________________ Dosage ________________ Frequency ____________________

Medication ________________ Dosage ________________ Frequency ____________________

FAMILY HISTORY

Has anyone in your family had any of the following: (Put an **M** for mother, **F** for father, and **B** for both)

___ High Blood Pressure

___ Heart Attack

___ Emphysema

___ Seizure-Convulsions

___ HIV Positive

___ Asthma

___ Diabetes

___ Kidney Disease

___ Ulcer or Stomach Problems

___ Stroke (Please indicate age when stroke occurred,

Mother _______ Father _______

___ Arthritis-Rheumatism

___ Mental Illness

___ Thyroid Disease

___ Circulation Problems

___ Cancer

Please add any pertinent medical information: ____

____

____

Are you currently experiencing or have you ever been diagnosed with any of the following?
Please check Y or N then initial at the bottom of the page.

CARDIOVASCULAR	Y	N
Aneurysms		
Bypass Surgery		
Chest Pain		
Deep Vein Thrombosis		
Heart Palpitation		
Heart Murmur		
High Cholesterol		
History of Heart Disease		
Pacemaker		
Pain in Legs After Walking		
Raynaud's Syndrome		
Shortness of Breath		
Stent		
Stroke		
Swelling Hands and/or Feet		
Syncope		
High Blood Pressure		

EARS, NOSE & THROAT	Y	N
Chronic Colds		
Chronic Strep Infections		
Dentures		
Dizziness		
Ear Pain		
Nose Bleeds		
Sinusitus		
TMJ		
Vertigo		

RESPIRATORY	Y	N
Asthma		
Dyspnea		
Emphysema		
Lung Cancer		
Tuberculosis		
Wheezing		

GASTROINTESTINAL	Y	N
Abdominal Pain		
Difficulty Swallowing		
Heartburn		
Hernia Nausea		
Stomach Cancer		
GENITOURNINARY		
Frequent Urination		
Kidney Infections		
Ovarian Cancer		
Prostate Cancer		
Recurrent Urinary Tract Infections		

MUSCULOSKELETAL	Y	N
Arthritis		
Bone Cancer		
Gout		
Joint Pain		
Joint Tumor		
Limited Range of Motion		
Multiple Myeloma		
Multiple Sclerosis		
Muscle Cramps		
Osteoporosis		
Scoliosis		
Muscle Weakness		
Muscle Tenderness		

INTEGUMENTARY	Y	N
Bruising		
Changes in Nails/Hair		
Psoriasis		
Skin Cancer		
Skin Rash		

NEUROLOGICAL	Y	N
Dizziness		
Numbness or Tingling in Arms/Legs		
Involuntary Movement		
Difficulty Walking		
Migraines		
Paralysis		
Seizures		
Vertigo		

CONSTITUTION	Y	N
Appetite Changes		
Fatigue		
Insomnia		
Light Headedness		
Loss of Sensation		
Night Sweats		
Weight - Sudden Gain		
Weight - Sudden Loss		

ENDOCRINE	Y	N
Diabetes Type I		
Diabetes Type II		
Hyperthyroidism		
Hypothyroidism		

GENERAL	Y	N
Drink Alcohol		
# / Week		
Smoke		
# / Day		

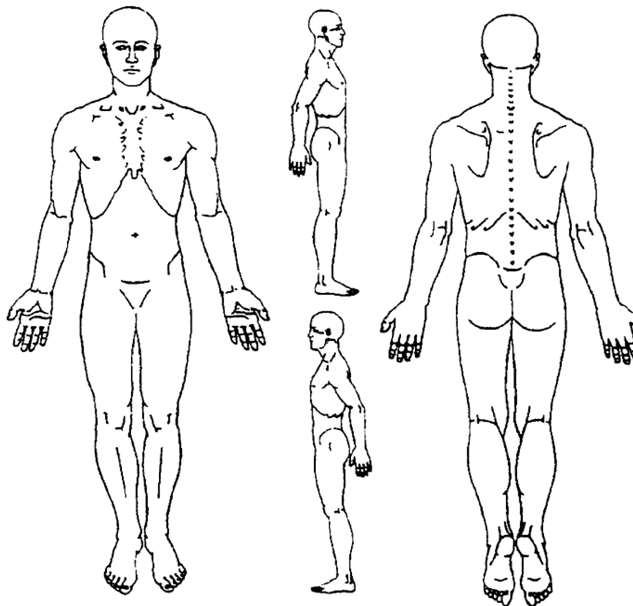
Initial: _______

(rev 7/11)

PAIN

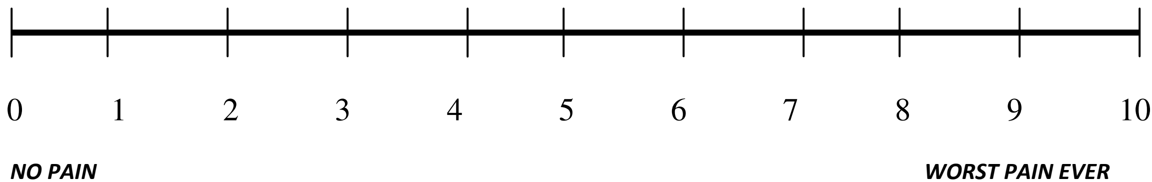
Please mark on the diagram the type of pain and location:

TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING… Place appropriate symbol or letter on the diagram. Ache = A Numbness = N Pins and Needles = O Burning = X Stabbing = /
WHAT IS THE INTENSITY OF YOUR PAIN? Please circle one… **Slight** **Minimal** **Moderate** **Severe**



NUMERICAL RATING SCALE

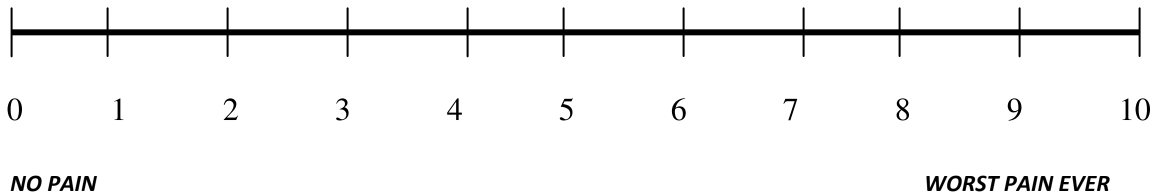
Please place a mark on the line that corresponds to your ***current*** pain for this condition (0 = No Pain, 10 = Worst Pain Ever).



0 1 2 3 4 5 6 7 8 9 10

NO PAIN ***WORST PAIN EVER***

Please place a mark on the line that corresponds to your ***worst*** pain for this condition (0 = No Pain, 10 = Worst Pain Ever).



0 1 2 3 4 5 6 7 8 9 10

NO PAIN ***WORST PAIN EVER***

When did the pain begin? __________ Any flare-ups since then? If yes, when?____________

What brought the pain on? ____

What makes the pain better? ____

What makes it worse? ____

How often does the pain exist? ___________________ And for how long? ______________

Any prior injuries? ____

Have you seen another healthcare practitioner for the pain/condition? ____

If so, who? ____

Signature____**Date**___________________

Consent for Use or Disclosure of Health Information

Integrated Sports Therapy (IST), PC Privacy Pledge

IST is very concerned with protecting your privacy. While the law requires IST to give you this disclosure, please understand that IST will always respect the privacy of your health information.

There are several circumstances in which IST may have to use or disclose your health care information.

- IST may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- IST may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- IST may need to use your health information within our practice for quality control or other purposes.

IST has a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (notice 164.520). IST reserves the right to change its privacy practices as described in that notice. If IST makes a change to its privacy practices, IST will notify you in writing when you come in for treatment or by mail. Please feel free to call IST anytime for a copy of its privacy notices.

Your Right To Limit Uses Or Disclosures

You have the right to request that IST does not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let IST know in writing. IST is not required to agree to your restrictions. However, if IST agrees with your restrictions, the restriction is binding to IST.

Your Right To Revoke Your Authorization

You may revoke your consent to IST at any time; however, your revocation must be in writing. IST will not be able to honor your revocation request if IST has already released your health information before IST receives your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

______________________________	________________________________
Patient Name (printed)	Signature of Chiropractic Physician
______________________________	________________________________
Signature of Patient	Date
______________________________	
Date	

GRASTON TECHNIQUE QUESTIONNAIRE AND INFORMED CONSENT

Please answer the following questions (Yes/No). Read the statements concerning Graston Technique, and sign below. If you have any questions, please ask your IST practitioner.

1. Do you bruise easily? __________
2. Do you bleed for a long period of time after you cut yourself? __________
3. Are you taking blood thinners or anticoagulants? __________
4. Do you take aspirin on a regular basis? __________
5. Do you take cortisone on a regular basis? __________
6. Have you ever had inflamed veins or blood clots? __________
7. Do you have surgical implants in your body? __________
8. Do you have diabetes or kidney disease? __________
9. Do you currently have any infections? __________
10. Do you have uncontrolled high blood pressure? __________

Graston Technique is an instrument assisted variation of traditional cross fiber or transverse friction massage. The Graston Technique instruments consist of six stainless steel tools of various sizes and contours. Graston Technique is a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment
2. Reddening of the skin
3. Superficial tissue bruising
4. Post treatment soreness

Graston Technique is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

Graston Technique has several basic components. The IST practitioner will determine the protocol for each patient individually.

1. Graston Technique Instrument Assisted Soft-Tissue Manipulation
2. High repetition, low load exercise
3. Home stretches for treatment areas
4. Low repetition, high weight exercise
5. Stretching / rehabilitation exercises

All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Your signature ____ Date ________________________