Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to HealthSource!

Patient Information

First Name: __________________ Middle _______________ Last _________________ Gender: __M __ F __ X

Address: ____

City: _________________ State: __________ Zip Code: _______________

Home Phone: ____________________________ Cell Phone: _______________________________________

Email Address: ____ Birthdate: _______________ Age: _____

Marital Status: __ S __ M __ W __ D Job Title: _________________________ Work Phone: ________________

Spouse Name: ____________________________ Birthdate: ____

Children: Names and Ages:____

Insurance Subscriber/Primary Policy Holder Information

Name of person on the insurance card: ____ DOB:_____________

Name of employer: ____

Employer phone number: _____________________________________ City: ______________________________

Person responsible for this account: ____

Additional Information

In case of emergency, whom should we contact? ____

Relation to patient: ____________________________ Phone Number: ____________________________________

Family Physician: ____

May we send your Family Physician updates on your progress? __________Yes _________ No

What is your primary complaint? ____

____

Is this worker's compensation? _____________________ Is this personal injury? _________________________

Office use only **Account Number** **Date**

AMS Checklist

Place an "X" for EACH symptom you are currently experiencing. ***Please mark only ONE box.***
For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2.	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4.	**Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9.	**Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13.	**Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.____________________________

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?________________________________

________**Recent PSA:**____________**Recent Digital Rectal Exam (Date):**________**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details.________________________

FOR OFFICE USE ONLY

CHART ID:__________________________**DOB:**______________**APPT DATE:**______________

PREMIER
PAIN
MANAGEMENT

Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practices has been made available to me. I also understand that this Notice is available by request.

____

Name of Patient or Legal Representative *Date*

____

Signature of Patient or Legal Representative *Date*

Facility Use Only

- ❑ Patient has been provided Acknowledgement of Notice of Privacy Practices and refused to sign.

____

Authorized Staff Signature *Date*

Statement of Patient/Client Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

I have read and understood my rights and responsibilities.

- Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.
- Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the **responsibility** to ask their providers questions about their care.
- Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan. • Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
- Patients/Clients have the **responsibility** not to take actions that could harm others.
- Patients/Clients have the **responsibility** to report fraud and abuse.
- Patients/Clients have the **responsibility** to openly report concerns about quality of care.
- Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

______________________________ Patient Signature

______________________________ Date

PATIENT CONSENT TO TREAT:

I hereby authorize the Doctor’s/ Nurse Practitioners’ of PREMIER PAIN MANAGEMENT to treat my case as they deem appropriate through the use of lab testing, traction, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, injection therapy such as deep or superficial injections, dry needling, and diagnostic testing. I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves. I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. The patient also agrees that he/she is responsible for all bills incurred at this office.

I hereby request and consent to the performance of medical examination, chiropractic manipulation, and manual therapy techniques along with other medical or chiropractic procedures that may be recommended by the medical provider, including various modes of physical therapeutic modalities and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the staff at Premier Pain Management named below and/or other licensed doctors of chiropractic and/or medical staff who now or in the future work at PREMIER PAIN MANAGEMENT.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Injections or Dry Needling: puncture of a lung (pneumothorax), discomfort, bruising, inflammation, injury and numbness at the site of injection, fatigue, dizziness, or light-head feeling after the injection, fainting or loss of consciousness during the procedure, severe allergic reaction.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I understand I have the right to consent to or refuse any proposed treatment at any point prior to its performance. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient/Guardian Signature__________________________ Date __________________

Witness Signature _________________________________ Date__________________

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

__________________________________ ____________________________________
PATIENT'S / GUARDIAN'S SIGNATURE INSURED'S SIGNATURE

____
DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I assign, authorize, transfer and convey to [PROVIDER/CLINIC NAME] all of my rights, title and interest to all of the insurance benefits to which I may be entitled according to my insurance policy with the companies noted to the extent necessary to provide for payment of my bill. I hereby designate, authorize, and convey to [PROVIDER/CLINIC NAME], to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as provided in 29 *C.F.R.* §2560.5031(b)(4)), with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. By signing this form, I understand that [PROVIDER/CLINIC NAME] is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

____ ______________________
Patient DATE

____ ______________________
Policyholder/Insured DATE

____ ______________________
PATIENT'S / GUARDIAN'S SIGNATURE DATE