PIONEER
SPORTS & PAIN CENTER
SPINE & ORTHOPEDIC REHAB SPECIALISTS

PATIENT INFORMATION			
Last Name:	First Name: M.I.:		DOB:
Mailing Address:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone:
SSN:	Sex (circle one): MALE / FEMALE		Marital Status: Single / Married / Divorce / Widowed
Employer:		Occupation:	
Primary Care Provider:		How did you hear about us?	
Email (parent/guardian email if patient is a minor):			
RESPONSIBLE PARTY (If patient is a minor please fill out parent/guardian)			
Last Name:	First Name: M.I.:		DOB:
Mailing Address:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone:
SSN:	Sex (circle one): MALE / FEMALE		Relationship to Patient:
ADDITIONAL INFORMATION			
Emergency Contact:	Phone:		Relationship to Patient:

PRIMARY INSURANCE	SECONDARY INSURANCE
Company:	Company:
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:
Relationship to Patient:	Relationship to Patient:
THIRD PARTY LIABILITY ** If this is a 3rd party liability insurance for an auto claim, we request all patients to consult with an attorney to understand how benefits work**	
WORKERS COMPENSATION	
Claim Number:	Date of Injury
Insurance Name:	Phone Number:
Adjuster Name:	Adjuster Phone:
Employer Name:	Phone Number:
Address:	City/State/Zip:
MOTOR VEHICLE ACCIDENT	
Claim Number:	Date of Injury
Insurance Name:	Phone Number:
Adjuster Name:	Adjuster Phone:

Patient/Guardian Signature: _____ Date: _____

PATIENT NAME: _____ DOB: _____

HEALTH HISTORY

Was your injury work related? ☐ Yes ☐ No DATE OF INJURY: _____

How were you injured? _____

CHIEF COMPLAINT: What is the reason for your visit? _____

Body Part: _____ ☐ Left ☐ Right ☐ Bilateral

PAIN: Rate your current pain on a scale from 0-10 ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Check all that apply: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Pins & Needle ☐ Constant ☐ Comes & Goes

REVIEW OF SYSTEM: Check the box next to any current symptoms:

☐ Fever/Chills ☐ Nausea ☐ Headaches ☐ Blurred Vision ☐ Breathing Problems
☐ Chest Pain ☐ Sore Throat ☐ Constipation ☐ Urination Problems ☐ Rashes

MEDICAL HISTORY: Please check any of your medical conditions:

☐ Heart Problems ☐ Osteoporosis ☐ Diabetes ☐ Thyroid Disorder ☐ High Blood Pressure
☐ Lung Problems ☐ Seizures ☐ Stomach Ulcers ☐ Rheumatoid Arthritis ☐ Kidney Problems
☐ Blood Clots ☐ Hepatitis C ☐ HIV/AIDS ☐ Other: _____

Have you ever been diagnosed with an antibiotic resistant infection (i.e. MRSA)? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

SURGICAL HISTORY: Pervious surgeries? Yes ☐ No ☐

_____

_____

FAMILY HISTORY: Please list any medical conditions that run in your immediate family:

_____

_____

MEDICATION: Do you take any medication ☐ Yes ☐ No If yes, please list:

_____

_____

PAIN CONTRACT: Are you in a pain contract with any physician? Yes ☐ No ☐ If yes, please list:

Physician Name: _____ Physician Phone: _____

ALLERGIES: Do you have any allergies? ☐ Yes ☐ No If yes, please list:

_____

SOCIAL HISTORY: Occupation: _____

Do you drink alcohol? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, what kind?: _____

Patient/Legal Guardian Signature: _____ Date: _____

PROTECTED HEALTH INFORMATION RELEASE

(PATIENTS 18 YEARS AND OLDER)

Please note that by signing this release you are not authorizing us to release your physical records. This authorization is to verbally discuss your healthcare with the individuals you list below.

☐ Only release information to me personally.

☐ I authorize you to speak with my adult family member or other individuals about my medical care, test results, or billing as identified below.

Name (please print): _____ Name (please print): _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

Name (please print): _____ Name (please print): _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

☐ I authorize you to leave information on my answering machine regarding my medical care and results.

☐ Other, please describe.

_____

_____

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

I hereby request that a copy or summary of my records, including laboratory or x-ray reports that you may have which contains information relevant to my present and future diagnosis and/or treatment to be released from Pioneer Sports & Pain Center to the following Medical Office, Health Care Provider, or Person(s):

Name of Medical Office, Health Care Provider, or Person(s):

_____

_____

Address: _____

Phone Number: _____ **Fax Number:** _____

Consent for Treatment

Consent for Treatment: I authorize the staff at Pioneer Sports & Pain Center to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Pioneer Sports & Pain Center as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

Release of Information: Pioneer Sports & Pain Center may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Pioneer Sports & Pain Center may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Pioneer Sports & Pain Center may release all or any part of my record to any federal, state, or local government body when, in the opinion of Pioneer Sports & Pain Center, such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

CANCELLATION & NO SHOW POLICY: Pioneer Sports & Pain Center is founded upon, quality patient care. We are dedicated to providing an empowering environment with individualized care to achieve optimal healing and functional recovery for our patients. If you should have to cancel an appointment, we kindly request **at least 24 hour notice.** For patients who do not provide **at least 24 hours advanced notice,** if we feel it is necessary, we will charge you a **$30 fee**. Please be advised if you late cancel **and/or** no show for **3** chiropractic and/or physical therapy appointments, your therapist may discharge you from care and send your referring provider a note regarding your non-adherence to your therapy plan of care.

Patient/Legal Guardian Signature: _____ Date: _____

Consent to Communicate

I understand that Pioneer Sports & Pain Center may send text messages, emails, or voice call reminders for my appointments. I also understand that I might receive on occasion messages and such that might inform me of any specials, upcoming events, or any other noteworthy information that may be pertinent to my care. If I no longer wish to receive messages from Pioneer Sports & Pain Center, I have the right to revoke this consent at any time.

Patient/Legal Guardian Signature: _____ Date: _____

HIPPA Privacy Act Acknowledgement

Pioneer Sports & Pain Center is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your privacy rights. The delivery of your health care service will in no way be conditioned upon your signature acknowledgement, we will continue to provide you treatment, and will use and disclose you protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received this Notice of Privacy Practice for Pioneer Sports & Pain Center.

Patient/Legal Guardian Signature: _____ Date: _____

Financial Policy Statement

It is the patient's responsibility to know their insurance policy and its limitations. Patient agrees to pay for all portions of services in full at the time services are provided by our office. Although we check the patient's insurance benefits as a courtesy, it is crucial that the patient is personally aware of his/her insurance benefits. If the patient's insurance company denies service for prior authorization or no referral on file, the patient is responsible for the timely payment of services. The patient is required to present a valid insurance card at his/her first visit and as needed throughout care. If there are any changes to the patient's insurance, he/she is responsible to advise us of those changes and present the new card.

Financial Consent: I agree to be responsible for payment of any therapy charges which are not covered by my insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Pioneer Sports & Pain Center will bill me, my family, and/or other responsible parties for services provided.

Supplies: We do not bill supplies to the patient's insurance company. He/she will be responsible for all supply costs. This includes, but is not limited to, tape, Therabands, ice packs, brace supports etc.

Insurance Carriers: We bill most insurance carriers for the patient if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Understand that **unless the balance has been finalized by your insurance, any patient portion that is due is an estimate based on your insurance policy and their contracted rates, it is not a guarantee.** Any overpayment will be applied to future visits or, if requested, may be refunded to the patient after treatment is completed.

Assignment of Insurance Billing: I and/or the responsible party voluntarily assign Pioneer Sports & Pain Center and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

Self-Pay: Our self-pay option is $125.00 for the initial appointment and $85.00 thereafter. Payment is due at the time of service.

Dry needling is not typically covered by insurance and is $45 with any other service or $75 for a standalone appointment.

Methods of Payment: Our office accepts the following payment methods: cash, personal checks, VISA, MasterCard, Discover, Care Credit, and American Express credit cards.

We will assess a $20.00 charge on all returned checks.

Any other arrangements made with the front office will be as follows; *Monthly payments are required to pay off the patient's account balance within 3 months of the first invoice date, with an account balance due of no more than $1,000 to avoid being sent to collections.* If the patient's balance has reached $1,000, treatment will be stopped unless otherwise directed by the treating therapist. If the patient's account is not paid according to terms, the patient understands that our office reports to an outside collection agency. **The patient is ultimately responsible for all fees or services. I understand and agree to the FINANCIAL POLICY STATEMENT above.**

Patient/Legal Guardian Signature: _____ Date: _____