



S. Kyle Burtenshaw, DC
Dustin D, Elliott, DC
Ashley Hall, FNP
Cara Carpenter, DPT

We believe in empowering patients to make informed decisions as your partner in health

Dear New Patient:

We would like to take this opportunity to welcome you to Pioneer Sports & Pain Center!

We are pleased that you have chosen our team of healthcare professionals to care for you. It is our pleasure to provide you with the highest quality healthcare and service. Our doctors and therapists work together and collaborate to provide the best outcomes and patient focused care in the valley. We take a very holistic and comprehensive approach. Our practices are progressive and evidence based. We promise to give you our best, to treat you like a person and do all in our power to give you the best chance of living your best life.

We combine the best practices in sports and regenerative medicine, evidence based chiropractic rehabilitation along with Spine & Orthopedic Physical Therapy. We take the most comprehensive approach available to care for your acute and chronic pain. If we can't resolve your condition we refer out as needed.

As part of your contract with your insurance company, we are legally required to collect all co-pays and/or deductibles from you at the time of service. We ask that you are prepared to pay your copay and/or deductibles at the time of service. We conveniently accept the following methods of payment: Cash, Check, Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and other vendors upon request.

We are innovators and progressive physical medicine and rehab specialists. As our name Pioneer implies, we are committed to patient focused, data driven outcomes based on a progressive & compassionate health care delivery system. It is our privilege to earn your trust as your partner in health.

Again, thank you for allowing us to assist you with your healthcare needs.

Sincerely,

The Healthcare Team at Pioneer Sports & Pain Center



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 3 rd 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: _____

Financial Policy

Welcome to Pioneer Sports & Pain Center

We are pleased to have you as our patient. We are dedicated to providing quality, accessible, and cost effective health care services to our patients and we strive to make every visit a positive experience. This information was designed to provide our patients with a detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to communicate with your physician.

Registration

The registration process is a vital link in our office. Information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company.

Upon arrival at our office, you will be asked for basic information.

- *Current patient information: name, address, telephone number, employer, and emergency contact.*
- *Current insurance card.*
- *Driver's License or State ID*

Please arrive at least 15-20 minutes prior to your appointment time. Having information readily available will assist us in making the check-in process easier for you. Information obtained in the registration process is kept in your confidential medical record.

You will be asked to make co-payments at the Registration Desk at the time of service. For your convenience, we can also handle your payments on your account at the Registration Desk. We accept cash, check, debit cards and major credit cards (MasterCard, Visa, Discover & American Express).

Co-payments

Co-payments will be collected at the time of your visit. Please check with your insurance company for the requirements and provisions of your policy to determine the dollar amount of your co-payment prior to your appointment.

Families Divided by Divorce

We at Pioneer Sports and Pain Center understand that these situations require special handling. All efforts will be made to comply with your instructions regarding the billing. However, with the numerous problems that arise in divorce cases, the clinic can not act as administrator to resolve financial arrangements. The parent with whom minor children live with will be considered the responsible party and will receive all billing statements and correspondence. Both parents are legally responsible for the account balance.

Dependents

For your convenience, our statements show current account information for any family member who has used Pioneer Sports and Pain Center. Once a patient becomes eighteen, an account will be established in his or her name.

NSF Checks

There will be a \$20.00 charge for all returned checks.

Liabilities

Pioneer Sports and Pain Center does not protect third party liability charges. It is the obligation of the responsible party to settle any outstanding liability charges. Pioneer Sports and Pain Center can not act as administrator to resolve financial arrangements. The balance for services rendered is considered due in full at the time of the services.

Participation with Insurance Companies

Pioneer Sports and Pain Center reserves the right to determine which insurance companies or programs we participate with on an annual basis.

General Insurance Policy

As a convenience to you, our Insurance Staff will file a claim on your behalf provided we have your current insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package.

Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately, the patient is responsible for their Pioneer Sports and Pain Center charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know the details of their insurance contract and if Pioneer Sports and Pain Center is a network provider for their particular plan.

When your insurance company processes your claim they will provide you with an Explanation of Benefits (EOB). This EOB will explain what the insurance company has agreed to pay. Most insurance companies agree to pay only a percentage of the charges with the remaining balance being the responsibility of the patient. The EOB may use the term "Usual, Customary and Reasonable" (UCR). Insurance companies develop UCRs independently of one another. Medical Office maintains only one fee schedule and it is developed independently of the insurance company UCRs. Therefore, because of policy deductibles, co-payments, non-covered services and UCRs, you may have a balance due after insurance pays. No UCR adjustments will be honored unless the clinic has a signed contract in effect with that specific insurance carrier.

Medicare Policy

Federal law requires all physicians to file claims to Medicare.

Pioneer Sports and Pain Center accepts Medicare assignment. This means we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare.

If you carry a supplemental plan to Medicare, please be sure we have your policy information so that a claim can be filed for you.

General Credit Policies

All accounts are payable upon receipt of your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs.

If you are not covered by a medical insurance plan payment is expected at the time services are provided.

If you are from outside the Tri-State area you will be required to pay for your services prior to being seen regardless of your insurance status/coverage.

Payment in full or the amount not covered by your insurance carrier may be required prior to receiving care if you have a present/previous clinic account turned over to a collection agency, you currently have an overdue balance, or if you have a recent bankruptcy case.

Any account that has had a minimum of three balances turned over to a collection agency will be reviewed for a Credit Withdrawal of Care. Upon receipt of payment in full on those balances the Credit Withdrawal of Care may be rescinded.

Hardship

Patients who are having financial difficulties may qualify for a reduction in a repayment plan or a financial adjustment on their account. They will be required to complete a financial form and include the necessary information to process their application.

Missed Appointments

We reserve the right to charge for missed appointments and for canceled appointments if the cancellation is not made 24 hours prior the time of the scheduled appointment. A **\$60 charge** will be billed directly to you and be your responsibility. Please help us serve you better by keeping your scheduled appointment or by canceling prior to the day of the scheduled visit.

—> **\$60 missed appointment fee**

Questions Regarding Your Account

If you have questions regarding your account please contact our Patient Accounts Staff at the following telephone numbers: 208-922-4908

Billing questions:

Customer Service Staff,

208-922-4908 **Choose billing option

Credit Card Payments:

We accept debit cards and credit cards (MasterCard, Visa, Discover & American Express)

Thank you for your cooperation in helping us serve you with the highest quality, accessible and cost effective health care services.

VERIFICATION:

- ⬆ Patient Acknowledges Receipt of Financial Policy
- ⬆ Patient Refused Acknowledgement of Receipt of Financial Policy for the following reason(s):

Patient Signature

Date

Personal Health History

Please list all physicians that you see. (Please include Mental Health Professionals)

Name:	Address:	Specialty, or condition that is being treated:

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for Treatment	Beneficial Experience?

What health issues do you want to focus on during this visit?

Current Medical Problems: (e.g. diabetes, heart disease, hypertension, etc.)

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical History: List any major past illnesses, hospitalizations (include year or date if known).

Date		Date	

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still births	
Caesarian Sections		Pregnancy Terminations	
Abnormal PAP tests		Other GYN Procedures	

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other Cancer--what type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

Pharmaceuticals and Supplements:

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

Medication	Reaction	Medication	Reaction

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine:					

Please list all prescribed and over-the-counter medications you take regularly. Please include all supplements, vitamins or herbal products.

Medicine/ Supplement including Dose	Frequency	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? ☐ Yes ☐ No

	Date		Date
Pap/pelvic exam (females)		Tetanus vaccine (specify Td or Tdap)	
Mammogram (females)		Flu vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood (Stool Guaiac)		Zoster (shingles) vaccine	
Rectal prostate exam (males)		Hepatitis A	
Prostate Specific Antigen (males)		Hepatitis B	
Bone Density (Dexa)		MMR	
Eye exam		Gardasil (HPV vaccine)	
Cardiovascular stress test		Other	

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ☐ Yes ☐ No
If yes, is this an active issue in your life that you would like to address while you are here? ☐ Yes ☐ No

Movement, Exercise and Rest:

What forms of exercise and movement do you enjoy? _____

Please describe your physical activity:

Activity:	How often:	How long each time:

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep. _____

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Do you currently or have you ever had a problem with weight or eating? ☐ Yes ☐ No If yes, please describe: _____

Are you comfortable with your relationship with food? ☐ Yes ☐ No

Do you feel knowledgeable about your nutritional needs? ☐ Yes ☐ No

Who prepares your meals? _____

Personal and Professional Development:

Current or past occupation: _____

☐ Retired? ☐ Working at home? ☐ Care-taking? ☐ Disabled? ☐ Unemployed?

Are you happy with your occupation? ☐ Yes ☐ No

Why? _____

Do you anticipate any work changes in the near future? Retirement, etc. _____

Do you have a Racial/Culture heritage that is important to you? _____

Relationships:

Relationship status: _____ If married or partnered, what is your relationship length? _____

What are your living arrangements? _____ Number of children and ages: _____

Are you sexually active? ☐ Yes ☐ Are you happy with your sexual life? _____

Which relationship(s) fulfill and/or empower you? _____

Who or what drains your energy? _____

Physical Environment:

Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)? _____

Have you had hazardous environmental or occupational exposures? If yes, please describe. _____

What are your health goals? What are your overall goals for improving your health and your life? _____

Is there anything else that would be helpful for us to know about you? _____

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		GASTROINTESTINAL	Yes	No
Fever				Diarrhea/Constipation		
Sweats at night				Indigestion/heartburn		
Hot flashes				Nausea		
Temperature intolerance				Blood in stool		
Excessive thirst				GENITOURINARY		
Fatigue				Pain or burning on urination		
Sleep difficulties				Frequent urination		
Daytime sleepiness				Waking to urinate more than once at night		
Unplanned weight change				Excessive urination		
SKIN				Difficulty emptying bladder		
Rash				Urinary incontinence		
New or changing moles				Decreased sexual desire		
EYES				Pain with intercourse		
Pain				Sexually Transmitted Diseases		
Redness				Fertility issues		
Vision change				Men:		
EAR, NOSE, THROAT				Erectile dysfunction		
Hearing loss				Women:		
Ringing in ears				Heavy vaginal discharge		
Dizziness or vertigo				Heavy menstrual bleeding		
Bleeding gums				Painful menstrual periods		
Nosebleeds				Irregular menstrual bleeding		
BREAST				MUSCULOSKELETAL		
Breast Pain				Generalized or all-over pain		
Masses and or Lumps				Joint pain		
Nipple discharge				Stiffness		
Skin changes				Joint swelling		
CARDIOVASCULAR				Joint redness		
Chest pain				Back or neck pain		
Heart murmur				NEUROLOGICAL		
Irregular heart beat (palpitations)				Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema				Headache severe and/or frequent		
PULMONARY				Seizures		
Wheezing or shortness of breath				Muscle weakness, TIA or stroke		
Chronic cough				Fainting or loss of consciousness		
HEMATOPOIETIC				Localized numbness, tingling, neuropathy		
Swollen lymph glands				PSYCHOLOGICAL		
Blood clots				Anxiety		
Excessive bleeding				Depression		
Anemia				Memory loss		
				Mood swings		

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 part 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 healthcare 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.

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:** _____

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 members or other individuals about my medical care, test results, or billing as identified below.

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

Phone number: _____ Phone number: _____

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

Phone number: _____ Phone number: _____

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):

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 your 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: _____

Completed by: _____ If not patient, relationship to patient: _____ Date: _____