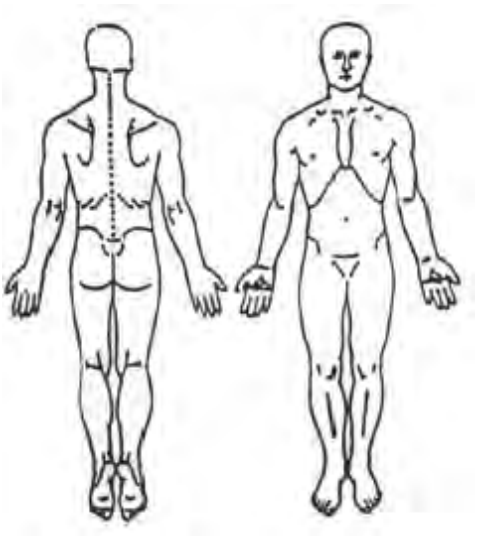
NEW PATIENT INTAKE

NAME _____DATE_____ PHONE_____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
BIRTHDATE_____ EMAIL_____ NAME OF PARENT(if minor)_____
EMERGENCY CONTACT_____ PHONE_____
WHO MAY WE THANK FOR REFERRING YOU?_____

THE REASON FOR THIS VISIT IS A RESULT OF (please circle) AUTO WORK FALL SPORTS CHRONIC OTHER
PLEASE DESCRIBE YOUR MAJOR COMPLAINT AND HOW IT HAPPENED_____
_____



DATE STARTED___/___/_____ HAD BEFORE?_____
PLEASE DESCRIBE _____
_____
_____

IS THIS INTERFERING WITH YOUR (please circle)
WORK SLEEP DAILY ROUTINE SPORTS RECREATION OTHER
IF SO, PLEASE EXPLAIN_____
_____
_____

ON THE PICTURES TO THE LEFT. PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS BY DRAWING AN "X" ON THE AFFECTED AREA

How you feel today (please circle):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

How often are your symptoms present?
___ 0 – 25% of the day(Intermittent)
___ 26 – 50% of the day
___ 51 – 75% of the day
76 – 100% (Constant)

HAVE YOU HAD	YES	NO	DATE	PLEASE DESCRIBE
MEDICAL CARE FOR THIS	___	___	____	_____
X-RAY, MRI, CT SCAN FOR THIS	___	___	____	_____
SURGERIES	___	___	____	_____
MEDICATIONS?	___	___	____	_____

HEALTH HABITS

ALCOHOL_____ /WK TOBACCO_____PACKS/DAY EXERCISE_____HRS/WK WORK_____HRS/DAY
COFFEE_____CUPS/DAY DRUGS_____ SLEEP_____HRS/NIGHT
VITAMINS_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the doctor or doctors office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient's Signature:_____Date:_____

If Applicable, Guardian's Signature Authorizing Care:_____ Date:_____

FUNCTIONAL BIOMECHANICS

PATIENT FINANCIAL AGREEMENT

In an effort to lower the cost of treatment for patients both with and without insurance, Functional Biomechanics has elected to operate as a time of service "Cash Practice" effective October 1, 2015. This allows us to offer a lower-priced fee schedule due to the lower administrative costs incurred by our office. The fees for services at Functional Biomechanics are a discounted rate of the federally approved reimbursement fee schedule for chiropractic services for the Phoenix area.

While some doctors offices charge an individual charge per service, we currently charge on an all inclusive, per visit basis. Unless additional charges are necessary to cover extra/additional care, supplements or supplies (which the doctor will discuss with you before treatment) our fees for standard appointments are:

$125 for the first visit (includes exam)

$75 for follow up visits.

All payments are due at time of service. We will provide you with a receipt that contains the procedure codes, diagnostic codes, amount paid and our contact information for the clinic along with the national provider ID number (NPI) for the treating provider. With the exception of Medicare Patients (please see Medicare Opt-Out Agreement) you may file a claim directly with your insurance company to request any reimbursement of costs they may allow. Please keep in mind, your insurance policy is a contract between you and your insurance company and our office will not directly engage in any processing of your claim for insurance submission. We will not be responsible for generating claim forms, filing claims, processing medical necessity support documents, writing reports or any other documentation with regards to processing claims. Patient medical records/office notes may be requested with 72 hours notice, hard copies may be subject to copying fees.

By signing this form, you agree that you are directly responsible for all costs of care incurred at this office. You further agree to hold this office harmless from any coverage decision your insurance company makes regarding payment should you elect to self submit for reimbursement.

_____ _____

Patient Signature (or Parent/Guardian if patient is a minor) Date

FUNCTIONAL BIOMECHANICS

CANCELLATION / MISSED APPOINTMENTS:

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time has been reserved just for you. Please arrive at least 5 minutes early to assist us in staying on schedule. Late arrivals will result in reduced appointment time. If you are more than 10 minutes late it may be necessary to reschedule your appointment. A minimum of 24 hours notice is necessary for cancelled appointments. Failure to notify our office in a timely manner is a financial burden and leaves a time slot open that could have be used to help someone else. Patients who do not give 24 hours advance notice for a missed appointment may be charged a fee of $50.00. Exceptions can be made for emergency/serious cases. It is our policy to keep a credit card on file for all patients. This card will *only* be charged in the case of a missed/late cancel appointment. Your information will be kept strictly confidential and under no circumstances, without prior patient consent, be used for any other charges.

Your signature below indicates your acknowledgement and acceptance of the terms outlined above.

Printed Name: _____

_____ _____
Patient Signature (or Parent/Guardian if patient is a minor) Date

CREDIT CARD ON FILE AUTHORIZATION

I have read and agreed to Functional Biomechanics cancellation policy. I hereby authorize Functional Biomechanics to charge the credit card listed below for payment of applicable charges to my account.

Please fill out the details as indicated below.

Card Holders Name:
(Exactly as it appears on card) _____

Card No: _____ Security Code: _____
Expiration Date: _____

Card Type:
Visa [ ] MasterCard [ ] Discover [ ] AMEX [ ]

Card Holders Signature: _____

Date: _____

A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended. The applicant must also notify Functional Biomechanics / Arizona Biomechanics if the credit card is cancelled, lost, or stolen and submit a new credit card authorization form with updated information.

FUNCTIONAL BIOMECHANICS

INFORMED CONSENT

Medical doctor, chiropractic doctors, osteopaths and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lighting. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Precautionary measures have been or will be performed to minimize the possibility of any complication from treatment and by signing below you freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effect associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guaranteed has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other qualified persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises can be of value when performed properly under supervision in a corrective nature, but if done improperly may aggravate or prolong the underlying problem.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recover.

Non-Treatment: I understand that the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ _____

Patient Signature (or Parent/Guardian if patient is a minor) Date