InMotion Spine – Muscle – Joint
Dr. Meryl Miller, Dr. Jared Shoemaker   Date: ________________

PATIENT INFORMATION

Patient: ____
Address: ____
____
City:________________State:________________
Zipcode:_____________ DOB:________________
Marital Status:________________________________
Patient SS#:________________________________
Occupation: ________________________________
Student at: ________________________________
Spouse Name: ________________________________
DOB: ________________________________
Occupation: ________________________________
Spouse Employer:

Who may we thank for referring you?
____

INSURANCE

Who is responsible for account: ____________________
Relationship to patient: ____________________
Insurance Co: ________________________________
ID#: ________________________________
Has patient additional insurance: yes no
Subscriber's Name: ____________________________
DOB: ________________________________
Relationship to Patient: ________________________
Insurance Co: ________________________________
ID# ________________________________

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with ______________________ and assign directly to InMotion SMJ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed: ____
Relationship ______________________Date:__________________

CONTACT INFORMATION

Home:______________Work: ____________________
Cell Number :________________________________
Email: ____
Best time and place to reach you:__________________

IN CASE OF EMERGENCY, CONTACT

Name:____
Relationship:__________________________________
Home#:________________Work#:________________

ACCIDENT INFORMATION

Is condition due to an accident? Yes No
Date of Accident: ________________________________
Type of Accident: auto work home other
To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp Other
Attorney Name: (if applicable): ____________________
Attorney Address: ________________________________
____
Attorney Phone: ________________________________

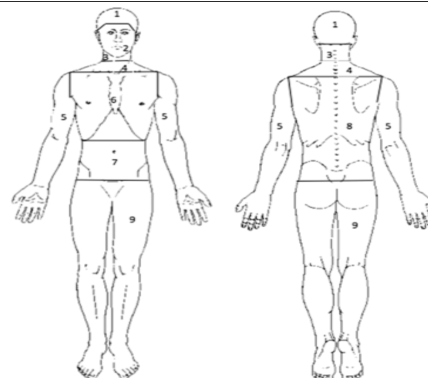
PATIENT CONDITION

Reason for Visit ____
When did the symptoms appear?____
What do you think caused the symptoms?____________________________________
Is this condition getting progressively worse? Yes No Unknown
Has this occurred before: ____________________ When:______________________________
Rate Severity of your pain: ____________________1 (least) to 10 (most)__________________________

Type of Pain: (circle all that apply)

Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

What time of day do symptoms occur?______________________
Is Pain constant or comes and goes? ______________________
Does it interfere with your work sleep routine
Days lost from work or school? __________________________
Activities you'd like to be able to do again? ____________________
____
Pain is reduced by:____________________________________



HEALTH HISTORY

What treatment have you already received for your condition? Medication Surgery PT Chiropractic None Other

Outcome of these treatments_______________

Name and address of other doctor(s) who have treated you for this condition? _______________

____

Is there anyone you would like me to keep informed regarding your treatment at this office?
(Family Physician, referring doctor etc) YES NO

Please specify name and address if known: _______________

Date of Last: Physical_______________ Spinal X-Ray_______________MRI CT Scan_______________
Bone Scan_______________ Chest X-Ray_______________

Any related symptoms/conditions_______________

Any recent Infections? YES NO Any fever or chills YES NO

Any dizziness? YES NO Any change in bladder or bowel habits? YES NO

Have you suffered from: (circle all that apply)

Backaches	Diabetes	Anemia	Migraines	Headaches	Hernia
Anxiety	Rheumatic Fever	Dizziness	Heart trouble	Cancer	Stroke
Arthritis	Numbness	Asthma	Osteoporosis	Pneumonia	Sinus Trouble
Epilepsy	Tuberculosis	Herniated Disc	Bleeding Disorder	Hypertension	
High Cholesterol	Multiple Sclerosis	Parkinson's	prostate Problem	Psychiatric Care	
Thyroid Problems		Other:_______________			

Has a physician treated you for any other condition(s) in the past 12 months? YES NO

WOMEN ONLY Is there any chance you may be pregnant? YES NO UNCERTAIN

EXERCISE	**WORK ACTIVITY**	**HABITS**
None	Sitting	Smoking ________Packs/Day
Moderate	Standing	Alcohol ________Drinks/Week
Vigorous <4x/wk	Light Labor	Coffee/Caffeine Drinks ________Cups/Day
Activities___________	Heavy Labor	Stress Level (low) 1 2 3 4 5 6 7 8 9 10 (high)
_______________	Other._______________	Stress Management Techniques Used:
		_______________

Please describe for us any hospitalizations, serious illnesses, falls, broken bones or surgeries you have had.

Year	**Reason**	**Hospital**	**Outcome**

Please list your prescribe mediations, over-the-counter medications, herbs, vitamins/supplements and inhalers:

Name	**Dosage**	**Frequency Used**	**Used For**

Please provide details of any known allergies (i.e. Latex, Food, medications etc)

Allergies **Reaction**

____

____

____

____

____

____

____

FAMILY HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives:

Conditions/Body System	**Self**	**Parent**	**Grandparent**
AIDS/HIV			
Arthritis			
Bleeding Disorders			
Cancer – Specify Type:			
Endocrine/Glandular (i.e. Diabetes, Thyroid)			
Hepatitis			
Immune			
Stroke/TIA			
Circulatory Problems (blood, heart)			
Ear, Nose and Throat			
High Blood Pressure			
Heart problems			
Neurological (brain, nerves)			
Gastrointestinal (stomach, intestines)			
Muscle/Joint/Bone			
Genitourinary (Kidney, prostate, Urinary)			
Psychological			
Respiratory (Lungs, Breathing)			
Skin			

I certify that all the information contained on this form is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature_________________________________ **Date**_____________________________________

All no call/no show appointments will be charge $30, late cancellation will be charged $25 charge.

Initials:________

NOTES

InMotion Spine Muscle Joint, LLC
FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

INSURANCE It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy for our records. We will request a copy at each annual office visit, or if you have not been seen in the past 6 months. If your insurance information changes at any time during your treatment, it is ultimately your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office. **It is the patient's responsibility to know their benefits and coverage**

Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copays, and non-covered charges.

REFERRALS Some insurance policies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

COPAYS Copays are due at the time of service. Copays are usually collected **PRIOR** to you seeing the doctor but may sometimes be collected after you have received treatment.

NON-COVERED SERVICES Dry Needling, Cold Laser, Taping and Normatec are considered non-covered services and are subject to patient responsibility.

MEDICARE If you are a Chiropractic Medicare patient it is your responsibility to pay for your exam on your first visit, at the time of service. While Medicare requires an exam they do not cover it. Exams are typically $60 - $80. Therapies are also not covered by Medicare, and would be your responsibility. Therapies are approximately are $20 - $28 and due at the time of service.

CASH PLANS Cash plans are available for patients who do not have insurance or do not wish to bill their insurance. Cash payments are $120 for the first visit and $60 for a routine visit. Payment is due at the time of service.

SUPPLEMENTS/MERCHANDISE Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to, swiss balls, supplements, foam rollers, vitamins and minerals.

(over)

RETURNED CHECKS The charge for a returned check is $30. This can be paid by cash, money order or charge. This will be applied to your account in addition to the original amount owed.

UNPAID/OUTSTANDING BALANCES, We ask that full payment be made at the time of service unless a prior arrangement has been made, with either your doctor or our billing office. If you have a deductible plan, once insurance has paid you will be mailed a statement. Prompt and timely payment is appreciated. **ANY OVERDUE BALANCES WILL BE CONSIDERED FOR COLLECTIONS**.

MISSED APPOINTMENTS We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide 24 hours notice, this will give us the opportunity to fill your cancellation. A $25 missed appointment fee may apply.

CREDIT BALANCES From time to time you may accrue a credit balance. Credit balances will be refunded at the patient's request. Refunds are made by check. After the request for a refund has been made, please allow time for review of your entire account and processing through our accounting system. Once approved please allow 30-45 days for your refund check to arrive.

I have read InMotion Spine Muscle Joint's Patient Financial Policy and acknowledge my responsibility with my signature below.

Print Name: (Patient, Parent or Guardian)____

Signature: (Patient, Parent or Guardian)____

InMotion Staff Witness:____

Date:____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC EXAMINATION AND TREATMENT

On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor may use their hands or mechanical devices to move, adjust or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to or refuse certain aspects of care once therapeutic options have been presented.

RISKS OF CHIROPRACTIC CARE AND TREATMENT

I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains to fracture or dislocation to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.9 – 5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time. I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if from some reason I am unable to reach or contact the practice, that I should telephone my Primary Care Doctor or present myself to the nearest hospital emergency room.

ALTERNATIVE TREATMENTS AVAILABLE

I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider and surgery. Each is associated with, their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment and management of my presenting condition(s) at any time.

CONSENT By affixing my signature, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction. **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to and authorize InMotion Spine Muscle Joint to conduct physical examinations, perform testing procedures are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to my, or my dependents current and past health history has been completed to the fullest extent and to the best of my knowledge and ability and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may, be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions which I seek examination and treatment for myself or my dependent.

Signature (Patient, Parent, or Legal Guardian)____

Print Name (Patient, Parent, or Legal Guardian)____

CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to InMotion Spine Muscle Joint to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

☐ YES ☐ NO

My child will be accompanied by (check all that apply):

☐ Himself or Herself

☐ Other:____

☐ Other:____

Signature: (Parent or Responsible Party)____