WELCOME TO OUR OFFICE!

By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

CONTACT INFORMATION

Date:_____/_____/_____

Name: (last)_____ (first)_____ (M.I.) _____

Street Address: _____ (apt. #) _____

(city)_____ (zip)_____

Phone: (home) (_____)_____-_____ (cell) (_____) _____-_____

Email address: _____@_____

Birth date: _____/_____/_____ Age: _____ Sex: _____ Drivers license#: _____

Married? Yes No **Social Security Number**: _____-_____-_____

Primary care physician:_____ Phone: (_____) _____-_____

Emergency contact: _____ Phone: (_____) _____-_____

Referred by: _____ Phone: (_____)_____-_____

EMPLOYMENT INFORMATION / STUDENT INFORMATION

Employer: _____ Phone: (_____) _____-_____

Job Title: _____

If student, school name: _____ Year in school: _____

INSURANCE INFORMATION

Please fill out the following insurance information to the best of your knowledge and provide a copy of your driver's license and insurance card(s) to the office staff so that your benefits can be checked prior to initiating treatment.

Name of Primary Medical Insurance: _____ Type: PPO HMO EPO

Name of Insured: _____ Relationship: _____

If name of insured is not you, please give their social security number: _____-_____-_____

Policy Number: _____ Group: _____

Name of Secondary Medical Insurance: _____ Type: PPO HMO EPO

Name of Insured: _____ Relationship: _____

If name of insured is not you, please give their social security number: _____-_____-_____

Policy Number: _____ Group: _____

MEDICAL HISTORY

ALLERGIES: (Please list all allergies, medicines, latex, food, etc.)

_____

_____

Are you currently taking any medications? Yes No

If Yes, please list **ALL** medications and strengths. (Example: Tylenol 200mg)

_____

_____

_____

_____

Do you now have/or have you ever had any of the following conditions (Please circle):

Alcoholism	Yes	No	Gout	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No
Edema (swelling)	Yes	No	Liver Disease	Yes	No
Bleeding Disorder	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Anxiety	Yes	No
Emphysema	Yes	No	Migraine Headaches	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No
Glaucoma	Yes	No	Stomach Ulcers	Yes	No
Drug Abuse	Yes	No	Sleep Apnea	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Heart attack	Yes	No	Tuberculosis	Yes	No
HIV/AIDS	Yes	No	Hepatitis A, B or C	Yes	No
High cholesterol	Yes	No	Cancer Type_____	Yes	No

If Yes, what type and what treatment was given:

_____

List any other diagnoses not listed above?_____

Female Patients

Are you pregnant? Yes No Date of last period: _____/_____/_____

SURGICAL HISTORY

Please list all surgeries and approximate **dates**:

_____

_____

_____

_____

FAMILY HISTORY

Have your close relatives (parent, siblings, grandparents, or children) had any of the following?

	Circle	Family Member		Circle	Family Member
Heart attack, angina	Yes No	_____	Osteoporosis	Yes No	_____
Seizures/Epilepsy	Yes No	_____	Anemia	Yes No	_____
High cholesterol	Yes No	_____	HIV/AIDS	Yes No	_____
Thyroid Disease	Yes No	_____	Stroke	Yes No	_____
Breast Cancer	Yes No	_____	Kidney Disease	Yes No	_____
Other Cancer? Type: _____	Yes No	_____	Diabetes	Yes No	_____

INJURY HISTORY

Please complete this page to the best of your knowledge. Please include **ALL** pertinent information regarding the injury you are currently seeking treatment for, as well as any past injuries or surgeries.

Are you right handed, left handed or ambidextrous? RIGHT LEFT AMBIDEXTROUS

Area(s) to be treated: _____

When did your symptoms begin: _____

Describe how the injury occurred:

_____

_____

_____

_____

Please list any symptoms (i.e. chest pain, shortness of breath, weight loss): _____

_____

Have you had previous treatment for this problem? (i.e. Physical therapy, injections) Yes No

Type of treatment	# of Treatments	Helped/Did not help
Acupuncture		
Physical Therapy		
Chiropractic Care		
Massage Therapy		
Injections		
Other: _____		

Have you had any diagnostic workup for this problem? (i.e. MRI, EMG nerve study) Yes No

If Yes, what did workup reveal? _____

Have you had surgery related to this condition? Yes No

If Yes, please list Doctor, date, and type of surgery: _____

What makes your pain worse?

_____

_____

What makes your pain better?

_____

_____

Any weakness in the upper or lower extremities? Yes No

If Yes, where?_____

Any numbness or tingling in the upper or lower extremities? Yes No

If Yes, where?_____

Any recent fevers or night sweats? If Yes, explain:

_____

Any changes in your bowel or bladder habits? If Yes, describe:

Pain Evaluation

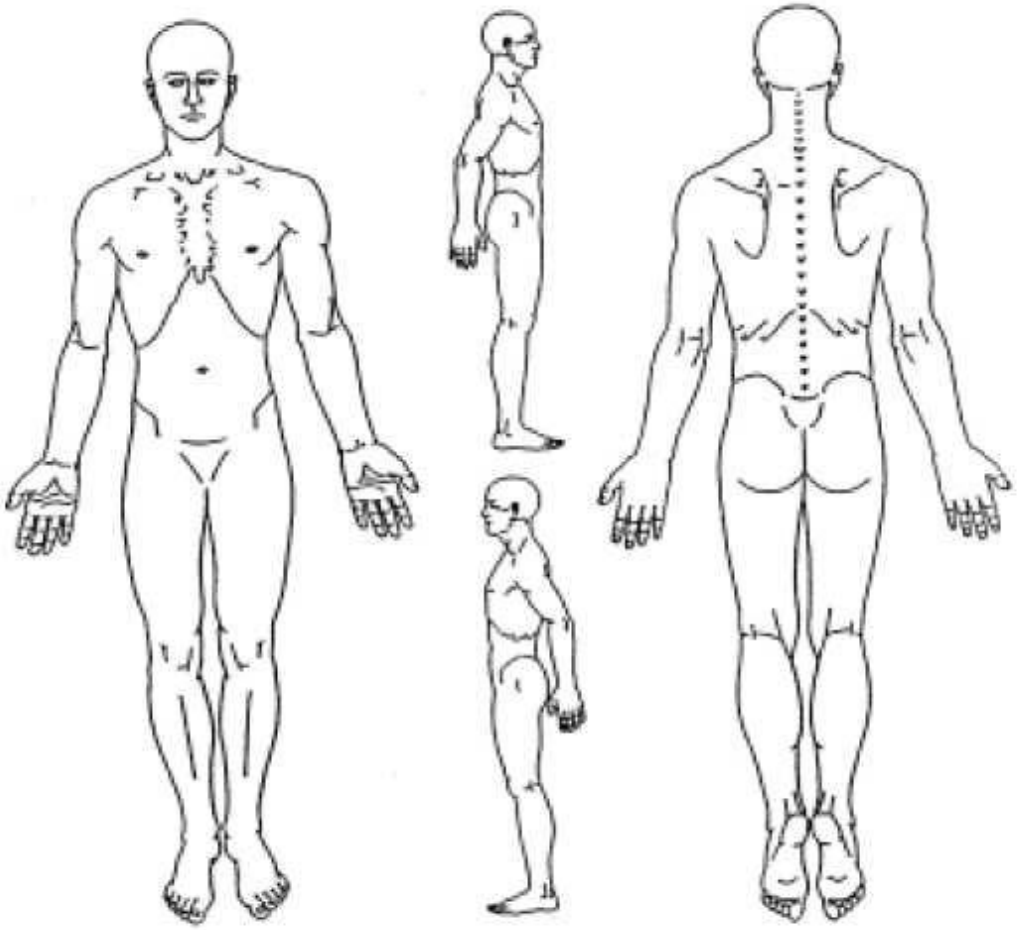
Please rate your pain **today** on the following numeric scale by **circling** the number which best describes your pain level.

0 1 2 3 4 5 6 7 8 9 10

No pain Emergency

At best my pain is ___/10. At worst my pain is ___/10.

Indicate your symptoms on the body diagrams using symbols in the key below:



Key

/////// Stabbing XXXX Ache 000 Pins & Needles ====== Numbness

Patients Signature_____ Date: _____

Patients Name: _____

Physician Signature: _____ Date: ____/_____/_____

Welcome to 360 Sports, Spine and Wellness! We are committed to serving your health care needs with dedication, professionalism, and compassion. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Office Policy and Payment Terms

Payment of co-payments, anticipated co-insurance, and deductibles will be collected in full and is due at the time services are rendered. For your convenience, 360 Sports, Spine and Wellness accepts Visa, MasterCard, American Express, Discover, Cash, and Check. It is the responsibility of the patient/member to verify that our office is affiliated with their insurance carrier or PPO prior to services being rendered. Also, it is the responsibility of the patient/member to understand their benefits and any plan restrictions or plan limitations. Please contact your insurance carrier directly for questions regarding your plan's benefits and any limitations therein.

We will provide you with an itemized statement of services or insurance claim form upon request. As a courtesy, 360 Sports, Spine and Wellness, inc. does provide insurance billing services. However, accounts not resolved within ninety (90) days from the date services were rendered, may be referred to any outside collection agency.

I, the undersigned, understand and agree to the above office policy and understand my participation and financial responsibility.

_____ _____

Patient Signature Date

If patient is a minor:

_____ _____

Parent/Guardian Signature Date

Payment Responsibility Form

Dear Patient:

360 Sports, Spine, and Wellness is committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Any and all co-payments, deductibles and co-insurance are due and payable at time of services. Professional services are charged to the patient. As a courtesy to you, we will complete necessary forms to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage.
_____ (initial)

Collection measures: Accounts not resolved within sixty (60) days may be referred to an outside agency for further follow up.
_____ (initial)

Assignment of Insurance Benefits and Private Insurance Waiver

1. I hereby authorize payment directly to 360 Sports, Spine, and Wellness of benefits due me for services rendered. I also hereby authorize 360 Sports, Spine, and Wellness to furnish information to my insurance carrier as necessary to secure payment of benefits, and hereby assign to 360 Sports, Spine, and Wellness any and all payments for services rendered.
2. I further agree that a photocopy of this agreement shall be as valid as the original.
3. I understand in the event any check or credit card payment is not honored by my bank or financial institution that I will be charged a service fee of $25.00, and I will be responsible to make immediate restitution to my account balance. I understand that subsequent visits may be on a cash basis only.
4. I understand that if my insurance carrier refuses to pay and/or process my claims or denies to authorize medical treatment for services rendered, that I will be financially responsible for the charges incurred at this facility.

Patient Name: _____

Patient Signature: _____ Date: _____/_____/_____

Disclosure Statement and Consent for Medical Treatment

This information is true and correct to the best of my knowledge. I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of the physician/therapist and I authorize this medical clinic and the physician/therapist to furnish information to the insurance carriers of this treatment. I also agree to any and all medical examinations, diagnostic and therapeutic recommendations as ordered or viewed as medically necessary per the Doctors and Associates at 360 Sports, Spine and Wellness, inc.

Patient: _____ Date: _____/_____/_____

Relationship of other responsible party: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

General Permission for Release of Medical Records

I _____ am hereby authorizing 360 Sports, Spine and Wellness, inc. direct access to my medical records, history's, laboratory results, etc., if available, per this request. I understand the medical confidentiality still prevails for both parties. I am also authorizing 360 Sports, Spine and Wellness, inc. to provide release of necessary documentation to myself and my insurance carrier in order to secure payment of claims for services rendered. I am also authorizing 360 Sports, Spine and Wellness, inc. to provide release of necessary documentation to my insurance adjustor, and/or attorney if applicable.

Patient Signature: _____ Date: _____/_____/_____

Important 360 Sports, Spine, and Wellness. Policies

Patient Responsibility Payment Extensions

All co-payment, co-insurance, or deductible payments must be paid at the time of your treatment. Any other arrangements must be made in person with the medical director.

Initial_____

24-Hour Advance Notice

If you wish to cancel an appointment, we require a minimum 24-hour advance notice. Anything less than that will result in a $50 fee applied to your account. In the event of an emergency or other such extenuating circumstances, please notify the office staff immediately to make the appropriate arrangements regarding your appointment.

Initial_____

Late Policy

Being late by more than 15 minutes may require your session to be modified at the discretion of the staff. In the event of extenuating circumstances, please notify the office staff immediately that you are running late so that the best course of action can be determined.

Initial_____

No-Shows

If you fail to show for 3 appointments without prior notice to the office staff, all further appointments you have scheduled will be removed. You may contact us and reschedule appointments on a "first come, first serve" basis, but it will not be guaranteed.

Initial_____

Patient contact information

In order to maintain constant communication, please make sure to provide a valid phone number and email address on the first page of the paperwork so that reminders can be sent regarding appointment dates and times. If you do not wish to receive reminders please inform the office staff at the time of your initial appointment.

Initial_____

I have carefully read and agree to all the above policies. In the event such policies are broken, I agree to the consequences set forth.

Patient Signature: _____ Date: _____/_____/_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.