Springbok Wellness and Rehab, LLC
Springbok Chiropractic, LLC

1400 N Gilbert Rd, Suite M
Gilbert, AZ, 85234
P (480) 558-0474 F (480) 558-0478

NEW PATIENT PACKET

FOR GENERAL INSURANCE & CASH PATIENTS

Patient Intake Sheet

Please note: All first visit charges are payable when services are rendered.

How did you hear about our Wellness Center?_____

Patient Last Name_____**First**_____**MI**_____

Address_____ **City** _____**State** _____ **Zip** _____

Home Ph: _____**Cell:** _____**Email:** _____

SSN _____/_____/_____ **Date of birth** _____/_____/_____ **Age** _____ **Height** _____**Weight**_____

Male ☐ **Female** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **# of children**_____

Current Employer _____Work ph: _____

Have you had Chiropractic, Physical Therapy, Occupational Therapy or Speech Therapy this year? ☐ **Yes** ☐ **No**

Which? _____

Referring Physician_____Primary Care Physician_____

Emergency Contact Information:

Name: _____ Relationship: _____

Primary Phone: _____

I authorize Springbok Wellness & Rehab and/or Springbok Chiropractic to release medical information to above named person in the event of an Emergency: ☐ Yes ☐ No

Insurance Information

Type of Insurance: ☐ **General Insurance** ☐ Worker Comp ☐ Auto/Personal Injury ☐ Medicare

Primary Ins Name: _____ Ins ID# _____

Group#: _____ Effective Date: _____

Secondary Ins Name: _____ Ins ID#: _____

Group#: _____ *Effective Date:* _____

Insurance Policy Holder

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Sex: ☐ M ☐ F

*Last:*_____First:_____MI:_____

*Birth Date:*_____/_____/_____

*Address:*_____ City:_____ State/Zip:_____

Home Ph: _____Work Ph: _____

Employer
Name:_____Address:_____

Please provide your insurance card and a photo ID to the receptionist for documentation purposes. All co-pays/fees for visits are due upon finishing initial paperwork and before seeing the treating clinician. Thank you.

Signature: _____ **Date:** _____/_____/_____

NOTE : We will do a courtesy insurance verification to see how much your insurance will help you with your care.

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HEALTH HISTORY FORM

HISTORY

Is this a work related or auto accident related injury? _____

What treatment have you already received for this condition?

___ Medications ___ Surgery ___ Physical Therapy ___ Chiropractic care ___ None

Exercise frequency: _____ Type of exercise: _____

Do you or have you ever smoked? Yes/No If so, how often? _____

Are you pregnant? Yes/No

Do you have a Pacemaker, Defibrillator or Neurostimulator? Yes/No

Allergies? _____

What medications are you currently taking? _____

_____

Previous surgeries/Date: _____ _____

_____ _____

_____ _____

Have you fallen within the last 6 months? Yes/No

DO YOU HAVE ANY OR HAVE HAD A HISTORY OF THE FOLLOWING?

AIDS/HIV	CHEMICAL DEPENDENCY	HEART DISEASE	OSTEOARTHRITIS
ANEMIA	CIRCULATION PROBLEMS	HEMOPHILIA	OSTEOPOROSIS
ANGINA	DEPRESSION	HIGH BLOOD PRESSURE	RHEUMATOID ARTHRITIS
ARTERIOSCLEROSIS	DIABETES	LOW BLOOD PRESSURE	STROKE
ASTHMA	EPILEPSY	LIVER PROBLEMS	TUBERCULOSIS
BLOOD CLOTS	EYE INFECTION	JOINT/BONE INFECTION	URINARY INFECTION
CANCER	FIBROMYALGIA	MULTIPLE SCLEROSIS	

CURRENT COMPLAINT

What is your major complaint? Please list all. _____

_____

When did it start? _____ Cause of pain/injury? _____

Previous treatment for current pain? _____

What positions or activities relieves your pain? _____

What time of day are symptoms worse? ___ Morning ___ Mid-Day ___ Evening ___ Bed time

Current duration of pain: ___ Intermittent ___ Constant ___ Certain motions

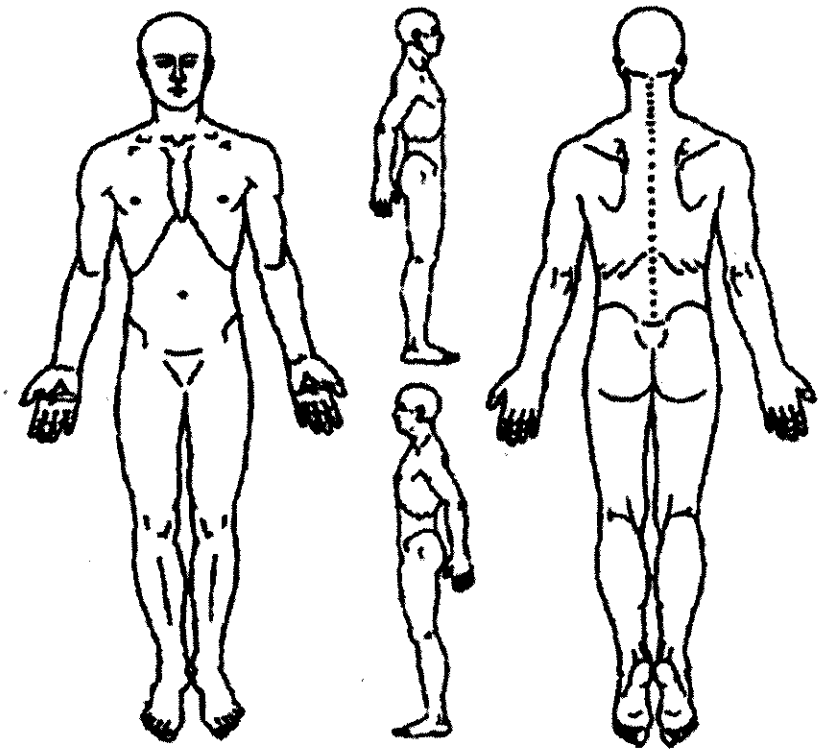
Current level of pain: 0-1-2-3-4-5-6-7-8-9-10 **(Zero is no pain; 10 is THE worst pain ever!!)**

How would you describe your pain? Dull Aching Throbbing Stabbing Pinching Shooting Burning

Is your pain getting better or worse? _____ Have you had this injury before? Yes/No

On the diagram below, please show **where** you are currently experiencing your present complaints using the following letters:

A: ache **B**: burning pain **C**: cramping **D**: dull pain **R**: throbbing pain **N**: numbness **T**: tingling



DO YOU HAVE PAIN AND/OR DIFFICULTY PERFORMING ANY OF THE FOLLOWING ACTIVITIES? (CHECK ALL THAT APPLY)

PERSONAL CARE ____

LIFTING ____

WORK ____

DRIVING ____

SLEEPING ____

WALKING ____

SITTING ____

STANDING ____

BENDING FORWARD ____

Patient signature: _____

Date: _____

ROS: All systems reviewed and WNL except as noted in history of present illness and above: _____Dr. Initial

AUTHORIZATION TO RELEASE X-RAYS & INFORMATION

(Please print name and sign on signature line. Leave all other spaces blank. Do not date.)

I, _____, Birthdate: ____/____/_____

Request the following information:

___ X rays ___ MRI ___ History ___ Records ___ Reports ___ Diagnosis

Concerning my ___ Illness ___Accident ___ Injury ___Other

To be released to the Doctors at Springbok Chiropractic and/or Springbok Wellness and Rehab,

1400 N. Gilbert Rd. Ste. M, Gilbert, AZ, 85234 Ph: (480) 558-0474 Fax: (480) 558-0478.

I understand I have the right to receive a copy of this authorization upon request.

Signature: _____ Date: ____/____/_____

I am the: ____ Patient ____ Parent ____ Guardian

PLEASE READ CAREFULLY

Health Care Privacy Notice We are required by law to abide by the terms of the Health Care Privacy Consent and we are committed to maintaining the privacy of your protected health information (PHI). We may change and/or modify the terms of this Consent at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. A copy of the HIPAA document is available at the front desk for you upon request. Please submit record requests in writing and allow up to 10 days for record retrieval especially if archived. Records are stored in archive for 7 years; must submit name of patient at time of treatment.

Consent to Treat I understand that Springbok Chiropractic LLC and/or Springbok Wellness and Rehab LLC, its providers & staff are accepting my case based on health history, examination, and diagnostic test findings & believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination or providers care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of physical therapy and/or chiropractic there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains and/or other injuries or side effects that cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. To have maximum therapeutic benefit and healing you must follow the plan of care your provider establishes. Therefore, I give my full consent to the doctor/provider to render evaluation and treatment on me, or the minor for whom I am legally responsible.

Statement of Disclosure I understand all referrals are made in good faith and per necessity to improve patient outcomes. Under A.R.S. (Arizona Revised Statutes) 32-2051 (C), we are required by law to inform you in writing that your referring physician/chiropractic physician may derive either direct or indirect compensation related to your physical therapy.

Appointment and Valuable Policy Office hours allow our patients convenience to schedule appointments. If you must miss an appointment please notify us 24 hours in advance. If you miss multiple appointments without notifying us you will be charged a $25 cancellation fee. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file. Patients are encouraged to leave valuables at home. This Facility shall not be liable for the loss of or damage to any personal property.

Assignment of benefits/financial responsibility 1. We will verify benefits as a courtesy for you. Springbok Wellness and Rehab and/or Springbok Chiropractic does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits. 2. I authorize my insurance carrier to release information regarding my coverage to Springbok Wellness and Rehab and/or Springbok Chiropractic. I authorize agents of any hospital, treatment center or previous physicians to furnish Springbok Wellness and Rehab and/or Springbok Chiropractic copies of any records of my medical history, services, or treatment. I authorize the release of any medical information and/or reports related to my treatment to any physician or insurance carrier as needed. 3. My right to payment for all health products, therapy services, supplies, and durable medical equipment including major medical benefits are hereby assigned to Springbok Wellness and Rehab and/or Springbok Chiropractic. This assignment covers any and all benefits as payment of claims for services. If my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, or my representative, I will endorse such payments to Springbok Wellness and Rehab and/or Springbok Chiropractic. I guarantee payment of all charges for treatment provided to the patient below to Springbok Wellness and Rehab and/or Springbok Chiropractic. I understand I am financially responsible for all charges including but not limited to all copayments, deductibles and expenses not covered or paid by my insurance. I understand the unpaid balance is due in full upon discharge. If legal action is taken against this account I agree to pay for all legal fees associated with this action. If the industrial or auto insurance exhausts or refuses to pay, I authorize Springbok Wellness and Rehab and/or Springbok Chiropractic to bill my health insurance. I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

BY SIGNING BELOW, I AM WITNESSING THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND POLICIES. THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Signature: _____ **Date:**_____

Office Policy

Please note that if your 2018 deductible has not been met, you will be responsible for a visit cost of $75.00 per visit until your deductible has been met. We will be balancing the account accordingly and informing you of any difference on the account. If the balance due is more than $75.00 collected, you will be responsible for the difference. Please make sure your insurance has been verified for the New Year.

Thank you.

_____ _____

Patient Signature Date

Cancellation Policy

24-hour notice is REQUIRED for all cancellations or a $25.00 fee will be charged for the appointment time held. This policy applies to all patients including Medicare, Workerman's Comp and Personal Injuries. These fees are not covered by insurance companies and will be your responsibility.

Thank you.

_____ _____

Patient Signature Date