Dr. Travis DeArmon, DC
4412 W. Houston St
Broken Arrow, OK 74012
P: (918) 254-8700
Email: dr.travis@psaschiro.com
Website: www.psaschiro.com

Date: _____

Name: _____ **DOB:** _____

SSN: _____ **Email Address:** _____

(If Minor) Name of Parent of Guardian: _____ **Relation to Pt:** _____

Cell Phone: _____ **Home/Work Phone:** _____

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

Name of Spouse: _____ **Phone Number:** _____

Employer: _____ **Occupation:** _____

If you are a full time student, school name: _____ **Grade:** _____

Who is your Primary Care Physician? _____ **Phone Number:** _____

May we have your permission to update your medical doctor regarding your care? [ ] YES [ ] NO

Who can we thank for referring you? _____ **If no one, How did you find us?** _____

Person Responsible for Account: **[ ] Patient [ ] Mother/Father [ ] Spouse [ ] Guardian**

Cell Phone: _____ **Home/Work Phone:** _____

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

Emergency Contact NOT Living With You:

Name: _____ **Relationship:** _____

Cell Phone: _____ **Home/Work Phone:** _____

Insurance Information: Please give your insurance card to the front desk for us to get a copy.

Policyholder Name: _____ **Policyholder DOB:** _____

Relation to policyholder: [ ] Patient [ ] Mother/Father [ ] Spouse

Insurance Company: _____ **Ins. Phone Number:** _____

Insurance ID: _____ **Group #:** _____

Insurance, Payment, and Treatment Authorization:

I understand that health insurance benefits vary by plan and may contain exclusions, limitations, deductibles, co-payments, co-insurance, and other provisions that affect coverage. Insurance coverage is intended to assist with the cost of healthcare services and may not cover all services rendered.

The goal of Dr. DeArmon and ProActive Sport and Spine (PSAS) is to evaluate my condition and recommend a treatment plan that is medically appropriate and in my best interest. I understand that I am financially responsible for all charges incurred for services provided, regardless of insurance coverage, benefit determinations, or payment by any third-party payer.

I hereby authorize payment of any insurance or other healthcare benefits otherwise payable to me for services rendered by ProActive Sport and Spine to be made directly to ProActive Sport and Spine. I understand that any balance not paid by my insurance carrier or other third-party payer remains my responsibility.

I certify that the information I have provided on my patient registration forms, health history questionnaires, and other office documents is true, complete, and accurate to the best of my knowledge.

I authorize ProActive Sport and Spine to release and obtain medical information as necessary for treatment, payment, healthcare operations, insurance claims processing, referrals, and other purposes permitted under applicable federal and state privacy laws, including HIPAA.

I understand that returned checks, non-sufficient funds (NSF) transactions, declined electronic payments, or other unpaid balances may result in additional fees being assessed to my account. I further understand that ProActive Sport and Spine reserves the right to pursue collection of unpaid balances through lawful means. In the event collection efforts become necessary, I agree to pay all reasonable collection costs, court costs, attorney fees, and applicable interest permitted by law.

Payment is due at the time services are rendered unless prior arrangements have been approved by ProActive Sport and Spine.

I acknowledge and understand ProActive Sport and Spine's cancellation policy. If I fail to provide at least 24 hours' notice for a cancellation or missed appointment, I understand that a $30.00 cancellation fee may be charged to my account.

Acknowledgment of Notice of Privacy Practices

The following is a summary of how ProActive Sport and Spine protects your protected health information (PHI). A complete description of our privacy practices is available in our Notice of Privacy Practices. If you would like to review or obtain a copy of this notice, please inquire at the front desk.

I understand that ProActive Sport and Spine reserves the right to amend or revise its Notice of Privacy Practices at any time, as permitted by law. I may request a current copy of the Notice of Privacy Practices from ProActive Sport and Spine at any time.

I understand that I have the right to request restrictions on the use and disclosure of my protected health information for treatment, payment, or healthcare operations. Such requests must be submitted in writing. I understand that ProActive Sport and Spine is not required to agree to all requested restrictions but will comply with any restriction that it agrees to accept, except as otherwise required by law.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy and confidentiality of my protected health information.

I understand that my protected health information may be used and disclosed for purposes that include, but are not limited to:

- **Coordinating, planning, directing, and managing my treatment and follow-up care among healthcare providers involved in my care.**
- **Obtaining payment from insurance companies, third-party payers, or other entities responsible for payment of healthcare services.**
- **Conducting healthcare operations, including quality assessment activities, credentialing, licensing, certification, compliance reviews, and other administrative functions necessary to operate the practice and maintain quality patient care.**

Consent for Release of Medical Information

ProActive Sport and Spine will not release your protected health information to anyone other than yourself without your written authorization, unless disclosure is required or permitted by law.

I hereby authorize ProActive Sport and Spine to contact me regarding matters related to my chiropractic care, including appointment reminders, referral information, treatment-related communications, and other healthcare related matters. I understand that contact may be made by telephone, voicemail, email, text message, or other electronic means.

I also authorize ProActive Sport and Spine to discuss my medical information with the individuals listed below. This authorization shall remain in effect throughout my doctor-patient relationship with ProActive Sport and Spine unless I revoke it in writing.

I understand that by signing this authorization, confidential or privileged medical information may be disclosed to the individuals designated by me below.

Information may be released to the following individuals:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

Patient Signature: _____ **Date:** _____

ProActive Sport & Spine Financial Review and Assignment of Benefits

I understand that any applicable deductible, co-payment, coinsurance, or other patient responsibility amount is due at the time services are rendered. ProActive Sport & Spine accepts cash, checks, Visa, Mastercard, and Discover.

As a courtesy, ProActive Sport & Spine may verify my insurance benefits; however, benefit information provided by my insurance carrier is not a guarantee of payment. All claims are subject to the terms, conditions, limitations, exclusions, and medical necessity requirements of my insurance policy at the time the claim is processed.

I understand that insurance verification is an estimate only and that final determination of benefits is made solely by my insurance carrier upon receipt and review of the claim.

I hereby assign and authorize direct payment of any insurance benefits payable for services rendered by Dr. Travis DeArmon and ProActive Sport & Spine to ProActive Sport & Spine.

I understand and agree that I am ultimately responsible for all charges incurred for services provided, regardless of insurance coverage, benefit determinations, claim denials, network status, or payment by any third-party payer. In the event that my insurance company denies, reduces, or does not pay a claim for any reason, I agree to pay the remaining balance in full.

By signing below, I acknowledge that I have read, understand, and agree to the financial policies outlined above.

Patient Signature: _____ **Date:** _____

Patient Health Questionnaire

ProActive SPORT & SPINE

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

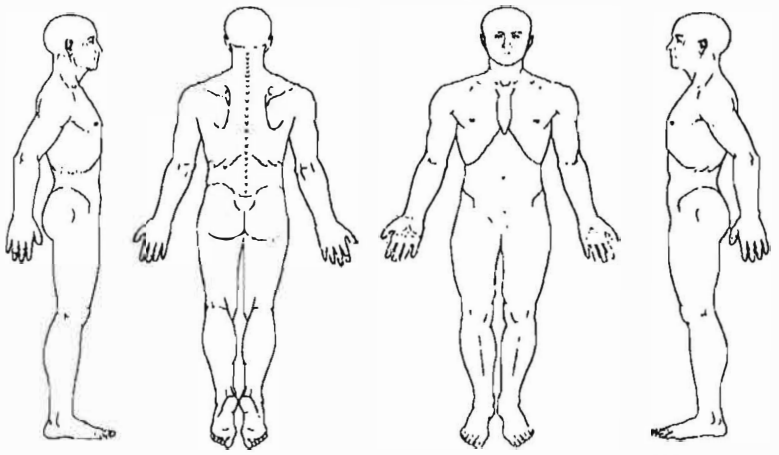
_____

_____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None									Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨ ⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ProActive SPORT & SPINE

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐☐☐ (*Feet* *Inches*) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	*Present*	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	*Present*	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Product
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	Birth Control Pills
☐	Hormonal Replacement
☐	Pregnancy
☐	

Other Health Problems/Issues

☐ ☐
☐ ☐
☐ ☐

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____