NEXT LEVEL

PHYSICAL THERAPY | CHIROPRACTIC | MASSAGE THERAPY

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:______________________________ **Date:**_________
Insurance: ____
Home ____________________________________
____
Date of Birth:_____________________________________
Marital Status: ☐ single ☐ married
Home Phone: _____________ **Cell:** _________________
Email: ____
Occupation: _______________**Employer:**____________

Mark (c) for current problems. Check and indicate the age when you were diagnosed.

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Autoimmune disease
☐ Bleeding disorders	☐ Cancer/Tumor	☐ Cardiovascular disease	☐ Chest pain
☐ COPD/Emphysema	☐ Depression	☐ Diabetes	☐ Difficulty breathing
☐ Dizziness	☐ Emotional/Mental disorders	☐ Epilepsy/Seizures	☐ Fatigue
☐ Fever	☐ Gallbladder disease	☐ Gastrointestinal disorders	☐ Gout
☐ Headache	☐ High blood pressure	☐ High cholesterol	☐ Irregular heart beat
☐ Kidney disorders	☐ Urinary disorders	☐ Unintentional weight loss/gain	☐ Loss of balance
☐ Loss of smell or taste	☐ Lung disorders	☐ Menstrual irregularities	☐ Migraines
☐ Numbness/tingling	☐ Osteoporosis	☐ Pacemaker	☐ Prostate disorders
☐ Previous surgery	☐ Pregnancy (___ weeks)	☐ Recent vision/hearing changes	☐ Shortness of breath
☐ Skin disorders	☐ Sleep disturbances	☐ Smoking	☐ Stroke (__/__/__)
☐ Swelling	☐ Thyroid disorders	☐ Ulcers	☐ Weakness
☐ Other			

Family History: *For blood relatives and indicate which relative(s)*

☐ Arthritis
☐ Autoimmune conditions
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Stroke

____
____
____

Past Health History: *if yes, explain briefly below*

☐ Hospitalization in the last 5 years
☐ Broken bones
☐ Joint replacements
☐ Strains/Sprains
☐ Surgeries

____
____
____

Please list any medications or dietary supplements you are currently taking and why:

____
____
____

Patient Intake Form (page 2)

Give a brief detailed description of what specific issue caused you to seek care:
____
____
____

What seemed to be the initial cause? ____
How long have you had this condition? ____________ Is it worsening? ____ Yes ____ No
Does anything make the condition better (certain activity, other)? ______________________________
Does anything worsen the condition (particular movements, other)?______________________________

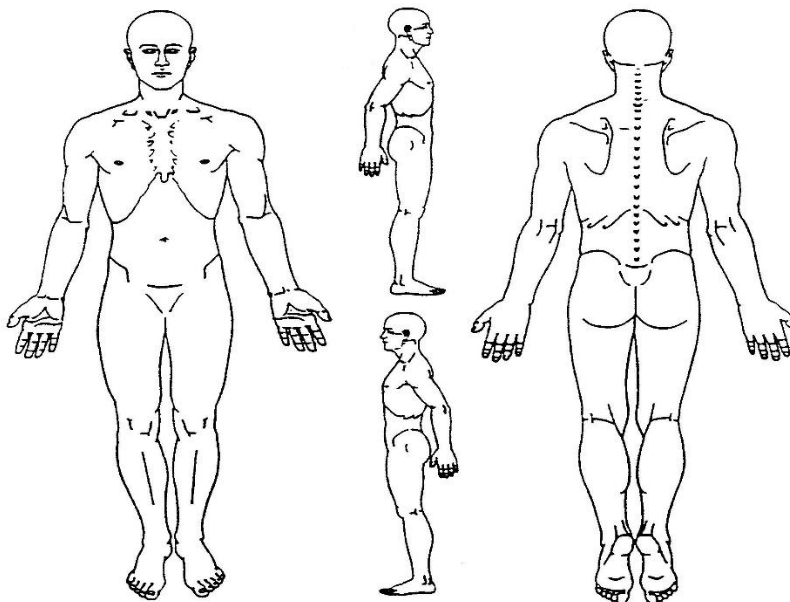
Have you received prior treatment (physical therapist, medical doctor, other)?____________________
If so, what was the treatment, and what were your results? ______________________________

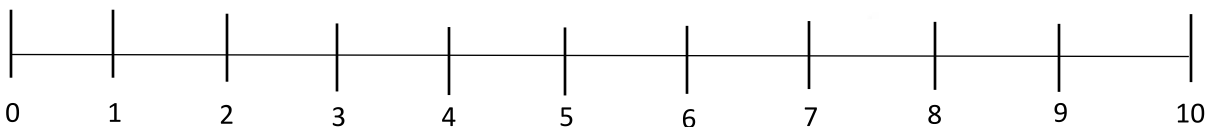
____

Have you had previous diagnostic testing? ____ X-ray ___ CT ___ MRI _____ other _____________
When/Where? ____

What is your goal for seeking care today? ____
____

Mark the area(s) of complain indicating what you have been experiencing: P= Pain, T= tightness, N numbness or tingling; W= weakness





CANCELLATION/TARDINESS POLICY

Effective as of April 1, 2020, Next Level Spine and Sports Injury Center will be instituting the following Cancellation and Tardiness Policy.

WE REQUEST 24 HOURS NOTICE FOR THE RESCHEDULING OR CANCELLING OF AN APPOINTMENT.
APPOINTMENTS RESCHEDULED OR CANCELLED WITHOUT 24 HOURS NOTICE WILL BE CHARGED A $35 CANCELLATION FEE.
IF YOU ARE 8 MINUTES LATE OR MORE, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULE AND YOU WILL BE CHARGED A CANCELLATION FEE.

All cancellation fee must be paid prior to scheduling your next appointment.

While we hope this will not be necessary, patients who repeatedly violate our Cancellation and Tardiness Policy may not be allowed to reschedule with Next Level.

Thank you for being a valued patient, and for your understanding as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Patient Signature___________________________ Date________

Informed Consent Form

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 lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Medicine Modalities: Other therapies used in this office include instrument assisted soft tissue mobilization, active release technique (myofascial release), electrical stimulation, Piezowave, kinesio-taping, normatec recovery boots, game-ready ice compression, and corrective exercises. Possible side effects of these treatments include muscle soreness, bruising, redness, petechia, joint pain, and skin irritation.

TREATMENT RESULTS I also understand that there are beneficial effects 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 guarantee 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 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. 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 recovery. Non-treatment: I understand 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. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient ____

Date:_____________________________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

By law, Next Level Spine and Sports (Next Level) is required to protect the privacy of your personal medical information. Next Level is also required to give you this notice to tell you how Next Level may use and give out ("disclose") your personal medical information held by Next Level.

Next Level **must** use and give out your personal medical information to provide information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

Next Level **may** use or give out your personal medical information for the following purposes under limited circumstances:

- To State and other Federal agencies that have the legal right to receive Next Level data (such as to make sure Next Level is making proper payments and to assist Federal/State Medicaid programs),
- For public health activities (such as reporting disease outbreaks),
- For government health care oversight activities (such as fraud and abuse investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and imminent threat to your or another's health or safety,
- To contact you about new or changed benefits under Next Level, and
- To create a collection of information that can no longer be traced back to you.
- To doctors, nurses and other professionals involved in your care **(this includes Coaches and Trainers)** to inform them of relevant symptoms, response(s) to treatments, etc., to insure successful delivery of chiropractic services.
- To insurance company(s) or other parties identified by you for purposes of payment of services. Information will be used to prepare invoices, bills, statements, etc.
- To individuals identified by you as being approved to view, hear, discuss private health information regarding billing, care given, etc.

- We may use your information to contact you in an effort to schedule appointments, discuss billing issues and inform you of relevant services which may be of interest to you. You may request a specific avenue of contact
(i.e. email, etc.)

By law, Next Level must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Next Level has already acted based on your permission.

By law, you have the right to:

- See and get a copy of your personal medical information held by Next Level.
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Next Level agrees. If Next Level disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Next Level. The listing won’t cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Next Level operations, or that was given out for law enforcement purposes.
- Ask Next Level to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Next Level to limit how your personal medical information is used and given out to pay your claims and run the Next Level program. Please note that Next Level may not be able to agree to your request.
- Get a separate paper copy of this notice.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Next Level is required to follow the terms in this privacy notice. Next Level has the right to change the way your personal medical information is used and given out. If Next Level makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

____   ______________________

Patient (Guardian) Signature   Date

If there is a preferred point of contact (example: a trainer, coach or doctor etc.) should it be asked of our facility to release records regarding your care,
Please specify a name, and their title/ position: ___________________________________

Patient Insurance Responsibilities:

I ____________________ understand that, as a courtesy, the staff at Next Level will do their best to verify the insurance benefits dictated by my individual insurance policy as it relates to the services rendered at Next Level. However, I understand it is my responsibility to also verify my insurance benefits directly with my insurance provider.

Insurance companies can often communicate inaccurate benefit details to their contracted providers including, but not limited to copay amounts, visit exclusions and deductible responsibilities regarding specific services.

We wish this was not the case however it is an unfortunate reality.

In the event that my insurance company inaccurately communicates my coverage to Next Level, I understand that I am still financially responsible for the benefits dictated by my insurance policy including copays, co-insurances, and deductible amounts due for applicable in-network, or out of network benefits with Next Level.

Similarly, because insurance companies often dictate a maximum number of visits, I will also be held responsible for knowing what this limit is per my individual insurance policy. I will be held responsible for tracking the number of visits accumulated with my services at Next Level. If I have reached this visit limit, I will be responsible for paying the cash rate for visits not covered thereafter.

If I have any questions regarding the benefits applicable to the services rendered by Next Level, I understand that it is my responsibility to seek clarification with the front office staff, or with my insurance company.

Patient Signature:______________________________ Date: ________________________

Next Level Physical Therapy Patient:

You are receiving this form to be made aware that we are required by the state of Pennsylvania to obtain a Physical Therapy prescription “script” from an overseeing physician for your Physical Therapy treatment.

If you are a patient using Medicare, Medicaid, TriCare, or if you are utilizing Automotive or Workers’ Compensation Insurance for coverage, we are required by law to always have a physical copy of this prescription on file during the course of your treatment. This includes your first visit.

If you are utilizing any other insurance company or electing to pay cash, Dr. Lauren Wentz, Dr. Lindsay Bonsra, and Dr. Shona Young have Direct Access Licenses issued by Pennsylvania to allow for treatment without a prescription for 30 days. After the end of the initial 30 days, law requires a Physical Therapy prescription to continue treatment.

By signing below, you certify that you understand the information stated above. You also certify that if you, or your physician, fail to provide a prescription when required by the State of Pennsylvania you will not be able to receive Physical Therapy treatment with Next Level Spine and Sports.

Patient Name: ____

Patient Signature: ____

Date: ____