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

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 **one** 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)?_____

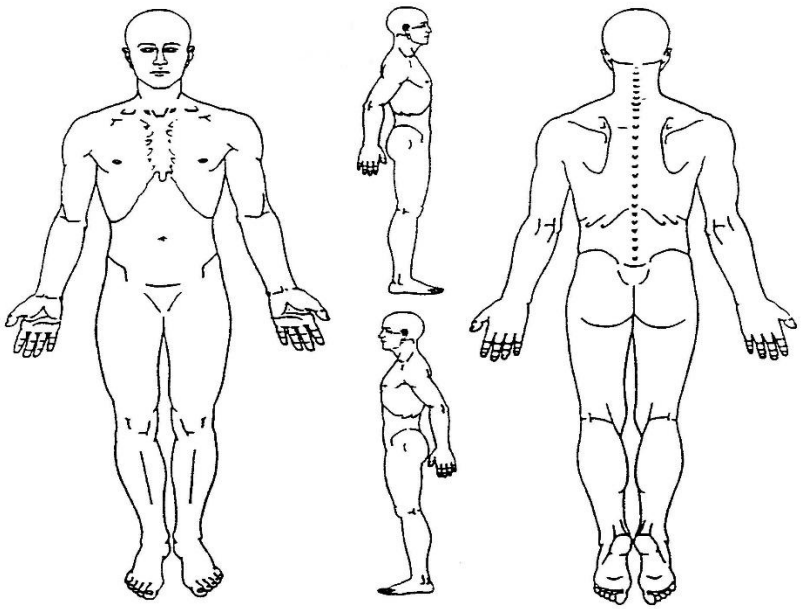
Have you received prior treatment (physical therapist, medical doctor, other)? ____Yes ____No
If so, what was the treatment, and what were your results? _____

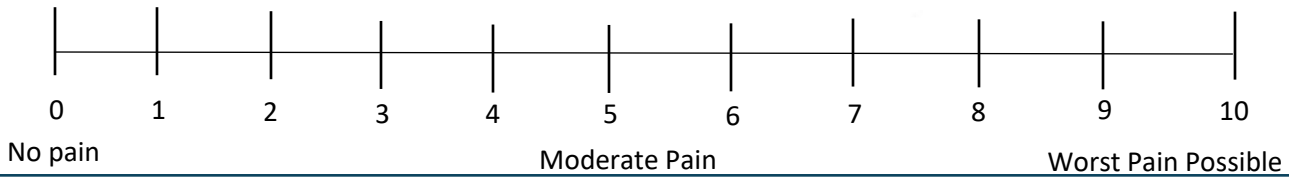
_____

Have you had previous diagnostic testing? ___ X-ray ___ CT ___ MRI __ Other:_____
When/At What Facility? _____

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





NEXT LEVEL

PHYSICAL THERAPY | CHIROPRACTIC | MASSAGE THERAPY

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_____

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

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

INFORMED CONSENT TO RECEIVE TREATMENT AND CARE

For your protection and the protection of your physician, Pennsylvania laws give patients the right to know about the treatment they receive. Sometimes, good practice requires that we tell you about risks associated with treatment or the use of medication, as well as the limitations of both. You are always welcome to ask for more details if you wish.

Fix Performance Medicine practices Acupuncture, Electro Acupuncture, Dry Needling, Cupping, Stretch Therapy and Exercise Prescription, which are Complementary and Alternative Medicine,s also called "CAM". Each patient is treated as an individual and there is no "one size fits all" course of diagnosis or treatment. Fix Performance Medicine physicians will consider CAM modalities, possibly recommending one or more practices, diagnostics, or remedies.

The CAM practices utilized may include, but are not limited to, one or more of the following: acupuncture; dietary supplements; exercise; lifestyle counseling; medicinal use of nutrition; massage; cupping; gua sha; (scraping therapy); moxibustion;; physical manipulation; electrical muscle stimulation; mind-body techniques; needle retention; tuina (Chinese manipulation); electrical, laser, and/or magnetic stimulation; micropuncture (mild bleeding therapy); diagnostic palpation on various areas of my body; and other energy therapies.

I understand that the diagnosis given to me conforms to the principles of (TCM) and in no way purports to replace allopathic (western) medical evaluation, diagnosis or treatment.

I have provided a full history and description of complaints and health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

I understand that no guarantee has been made concerning the use and effects of TCM. I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained

Different people react differently to the same treatment or drugs. I understand it is only possible for my physician to properly manage my care only if I communicate any difficulties I am having, or if medications are not effective or causing me discomfort.

I understand that I may stop treatment at any time.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

Acupuncture: I understand that it is a technique using small, sterile, stainless needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used. The location of the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the

needling site or fainting. Momentary euphoria or lightheadedness may occur after acupuncture treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause of concern. Some very rare risks of acupuncture include pneumothorax and infection. Rarely, massage and bodywork may cause a temporary increase of symptoms or new symptoms may present.

Electro-Acupuncture: I understand that I may be given electrical stimulation to the acupuncture needles. This technique is used to reduce muscular tension and pain as well as activate underactive muscles and improve blood flow to anatomical tissues. I understand I have the right and responsibility to inform the practitioner if the electrical stimulation is uncomfortable and the treatment can be stopped anytime. I understand that the areas may be sore after receiving acupuncture and electrical stimulation.

Cupping: I understand it uses round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injuries.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Therapeutic and Corrective Exercise: I understand that I may be given therapeutic and corrective exercise to perform on my own. These exercises are meant to correct movement dysfunctions that could be a contributing factor for the condition I am seeking treatment for. I understand that these exercises may create some discomfort which could include but are not limited to: muscle soreness, an exacerbation of symptoms, and tightness of soft tissue. If the exercises create pain, I understand that I can stop the exercises and contact Derrick McBride LAc, CFST, CSCS.

I understand that Fix Performance Medicine LLC cannot be expected to be able to anticipate and explain all risks and complications. I understand and agree that my physician will exercise judgment during the course of treatment which they feels at the time, based on the facts know then, is in the best interest of me as the patient. Medicine is very complex. New research and experience constantly provide beneficial changes in diagnosis and treatment. Although every physician wishes to do their best, no physician can guarantee a cure or promise a perfect result in every case.

Contraindications for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy.

Potential benefits of treatment include but are not limited to: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert Derrick McBride LAc, CFST, CSCS if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Privacy: I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law.

Cancellation Policy: Late cancellation is within 24 hours of a booked appointment. I understand if I cancel with less than 24 hours notice, or if I miss a booked appointment, I will be charged the full price for the appointment. I also understand that if I am more than 15 minutes late to an appointment, the remainder of the time-slot may be given to another patient.

Non-Refundable Payment Policy: I understand that all services purchased are non-refundable. No refunds will be provided for the full or partial price for any unused services, packages or gift certificates purchased.

Patient Authorization and Consent for Treatment

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner; and I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Written): _____

Patient Signature: _____

Date: _____