PATIENT INFORMATION

PATIENT NAME: ____ DATE OF BIRTH: _____ / _____ / _________

GENDER (circle one): **Male Female Non-Binary Other:** _____________ MARITAL STATUS (circle one): **S M D W**

ADDRESS: ________________________________CITY: ________________________STATE: ______ZIP: _____________

PHONE #: _____________________________ EMAIL: ________________________ SOCIAL SECURITY NUMBER: _____-____-______

REFERRING PHYSICIAN: ______________________________

WERE YOU REFERRED FOR **POST-OPERATIVE** PHYSICAL THERAPY? **Y / N** DATE OF SURGERY : ______ / ______ / _________

PRIMARY CARE PHYSICIAN (if different from Referring): _______________________________ PHONE #: __________________________

CLINIC NAME / ADDRESS: ____

EMERGENCY CONTACT NAME: ____________________________________ PHONE #: ___________________________

RELATIONSHIP TO PATIENT: _________________________________

BILLING INFORMATION

If you do not have a physical copy of your insurance card, please email a digital copy to laura@returntohealthllc.com.

PRIMARY INSURANCE CARRIER: ________________________________ **PPO / HMO**

ID#: _________________________________ GROUP #: ______________________

NAME OF POLICY HOLDER (if not the patient): ___________________________________

POLICY HOLDER DATE OF BIRTH: _____ / ______ / __________ EMPLOYER: ______________________________

INSURANCE CARRIER: ________________________________ **PPO / HMO**

ID#: _________________________________ GROUP #: ______________________

NAME OF POLICY HOLDER (if not the patient): ___________________________________

POLICY HOLDER DATE OF BIRTH: _____ / ______ / __________ EMPLOYER: ______________________________

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits to be made directly to Return to Health, LLC. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care and benefits. I understand that I am responsible for all costs of care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

PATIENT AND/OR GUARDIAN SIGNATURE: _______________________________________ DATE: ____________________

PATIENT FINANCIAL RESPONSIBILITY AND CONSENT TO TREAT

[INSURANCE] I, ____________________________ consent to physical therapy and/or chiropractic services performed by Dr Andrew Garrett DC and the staff of Return to Health, LLC as well as allowing them to bill my primary and/or secondary insurance(s) for services rendered. Once billed, I authorize my health insurance provider to make direct payment(s) to Return to Health, LLC.

OR

[CASH PAY] I, ________________________, consent to physical therapy and/or chiropractic services performed by Dr Andrew Garrett DC and the staff of Return to Health, LLC and am forgoing the use of health insurance, therefore will be paying the facility's set cash prices for services rendered out of pocket each visit, due at the conclusion of treatment. Any remaining balance will be due at the date of discharge.

Patient Signature: ________________________ **Date:** ______________

Staff Signature: __________________________ **Date:** ______________

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of land-based and aquatic physiotherapy on me or on the patient named below, for whom I am legally responsible) by Dr. Andrew Garrett, DC and/or other licensed Doctor of Chiropractic who now or in the future work at Return to Health, LLC.

I have had an opportunity to discuss with Dr. Andrew Garrett, DC and/or with other clinic personnel the on the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the health care providers at Return to Health, LLC to be able to anticipate and explain all risks and complications, and I wish to rely upon healthcare providers to exercise reasonable judgment during the course of the procedure, based upon the information I have provided to them, and the facts then known by my healthcare providers.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 at Return to Health, LLC.

PATIENT / GUARDIAN SIGNATURE: _____________________________ DATE: ________________

PRINT PATIENT NAME: ____

WITNESS / STAFF SIGNATURE: ________________________________ DATE: ________________

HIPAA – Release of Information

Name: ____________________________________ Date of Birth: _____/____/__________

Release of Information:

_____ I authorize the release of information including the diagnosis, records, examination performed, treatment rendered to me, appointment scheduling, and claims information.

This information may be released to:

NAME: ________________________ RELATIONSHIP: ________________
NAME: ________________________ RELATIONSHIP: ________________
NAME: ________________________ RELATIONSHIP: ________________

_____ Information is NOT to be released to anyone.

How may we contact you? *(check all that apply):*

____ Phone Calls to Personal/Cell #

____ Text Message to Personal/Cell #

____ Email

____ Work #: _________________________

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] ____

The best time to reach me is (days)___________________ between (times)______________.

This Release of Information will remain in effect until terminated by me in writing.

Legal Representative or Patient Signature: _______________________Date:____/____/_____

RETURN TO HEALTH

Attendance Agreement

In order to maximize the benefits of therapy, it is very important that scheduled appointments be attended. The consistency of attending therapy sessions gives you the best opportunity to obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients. In signing this form, you indicate that you understand the attendance policy and the results of not keeping your appointments.

We anticipate that you will adhere to the following:

- I understand that if I arrive more than fifteen (15) minutes late, I may not receive therapy that day, depending on the providers' schedule(s), patient volume, and/or equipment availability and that the appointment can be rescheduled for a time/date that fits within the upcoming schedule.

- I understand that three (3) consecutive "no-call, no-shows" within a treatment plan of care, are grounds for discharge from therapy. The referring physician will be notified of my failure to show for appointments and the resulting discharge from therapy.

- I understand that if my regular provider is not available, I could be given the option to see another provider if one is available.

Following these guidelines will greatly assist in maintaining the flow of the clinic and allow clinicians to provide optimal care to all patients.

In signing this form, you indicate that you understand the attendance policy and the results of not keeping your appointments.

Patient/Guardian Signature ________________________________ Date _______________

RETURN TO HEALTH

PATIENT HISTORY FORM

Name: ___________________________________ Height: __________ Weight: __________

Are you **pregnant** or think you could be? [ ] **YES** [ ] **NO**

Do you have a **pacemaker**? [ ] **YES** [ ] **NO**

Have you **fallen** within the past 6 months? [ ] **YES** [ ] **NO**

Medical/Surgical History

Please check if you **have ever had** or **currently have**:

MUSCULOSKELETAL	*NEUROMUSCULAR*	*CARDIO/PULMONARY*	*OTHER*
__ Arthritis (Osteo/Rheumatoid)	__ Stroke/TIA	__ Heart Attack	__ Cancer
__ Osteoporosis	__ Head Injury	__ Hypertension	__ Diabetes
__ Fractures or Broken Bones	__ Parkinson Disease	__ Heart Disease	__ Autoimmune
__ Spinal Surgery	__ Fibromyalgia	__ COPD	__ Infectious Disease
__ Back / Neck Pain	__ Nerve Pain/Damage	__ Asthma	
__ Joint Pain	__ Seizures	__ Vascular Issues: ________________________	
__ Bone or Joint Surgery			

Other Problems Not Listed: ____

____

Please list surgeries and the dates performed: ____

____

____

Please list all current medications and dosages (*you can also provide a list that we can scan into your e-chart)*:

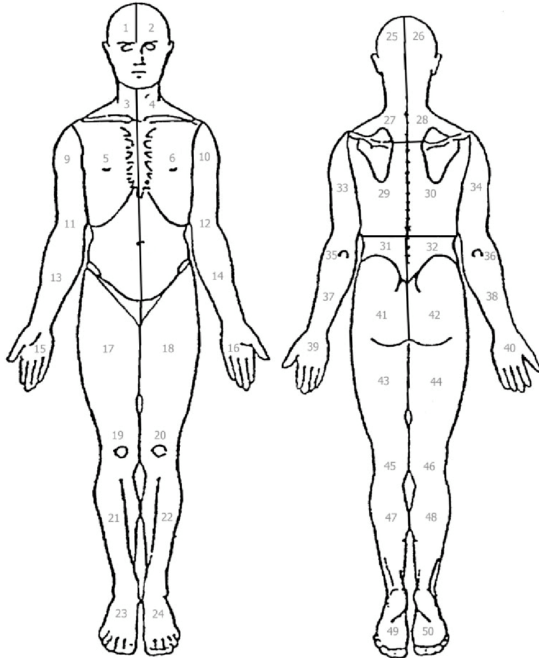
Medication Name	**Dosage**	**Frequency**

RETURN TO HEALTH

Please rate your pain level **MOST** (85 – 100%) of the time over the past **7 DAYS**:

[0 = no pain ---10 = worst pain imaginable] **0 1 2 3 4 5 6 7 8 9 10**

Indicate areas of pain, tightness, numbness, or tingling on the diagram.



Briefly describe the reason for your visit today:

____

____

____

Please list anything you have found that **aggravates**, or makes your pain/symptoms *worse*:

____

____

____

Please list anything you have found that **relieves**, or makes your pain/symptoms *less*:

____

____

____

In the past **6 months**, have you had any of the following diagnostic tests for your injury/condition? (Check all that apply.)

__ X-Ray (DATE: __________) __ Nerve Study (DATE: ___________)

__ MRI (DATE: __________) __ Ultrasound (DATE: ___________)

__ CT Scan (DATE: __________) __ Bone Scan (DATE: ___________)

__ OTHER: ____ (DATE: ___________)

Do you regularly see a **Pain Management Specialist** for your injury/condition?

____ YES ____ NO

Physician Name / Practice: ____

In the past **6 months**, have you received any pain management procedures such as injections or nerve ablations for your injury/condition?

____ YES ____ NO