THRIVE
SPINE & SPORTS REHAB

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Sex: M/F: _____ Age: _____ Marital Status: S / M / D / W Social Security# _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone #:_____ Cell #: _____

Email Address: _____

Employer: _____ Occupation: _____

In Case of Emergency Notify:

Name: _____ Phone Number: _____

How were you referred to Our Office?

Billboard/Google/Magazine/: _____Family/Friend: _____

Patient Medical History

Referring Doctor: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Reason for Today's Visit: _____

Describe your Symptoms: _____

Rate your pain (0= no pain, 10= worst imaginable pain) _____

When and how did it start? _____

What makes it better? _____ Worse? _____

Have you been treated for this condition in the past? YES / NO

If Yes, what treatments have you had?

_____

Do you have any questions or concerns about being treated?

_____

List all current Medications:			

Past Medical History:			
Diabetes	High Blood Pressure	Coronary Artery Disease	Vascular Disease
Heart Disease/Attacks	Congestive Heart Failure	Thyroid Disease	Depression
Lyme Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Porstate	Hepatitus	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Asthma	COPD
Cancer	Scoliosis	Stroke	Kidney Disease

Please list any Medical Conditions you may have that is not mentioned above:

Family Medical History:			
Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
Heart Disease/Attacks	Seizures	Strokes	Lung Disease
Rheumatoid Arthritis	Asthma	Scoliosis	Multiple Sclerosis

Please list any Medical Conditions your family may have had that is not mentioned above:

Past Surgical History:

Surgery	Date	Surgery	Date
Knee Arthroscopy (R / L)		Shoulder Arthroscopy (R / L)	
Spine Surgery (cervical/thoracic/lumbar)		Joint Replacement Surgery	
Hernia Repair		Hysterectomy	
Eye Surgery		Cardiac Catheterization	
Peripheral Bypass Surgery		Coronary Artery Bypass Graft	

Please list any other surgery you may have had that is not mentioned above:

Do you smoke? ____ Current Smoker ____ Former Smoker ____ Never Smoked ____ Pipe Smoker ____ Cigar Smoker ____
If Yes, how much do you smoke? ____ 3 cigarettes or less a day ____ 1/2 pack a day ____ more than a pack a day

Do you drink alcohol? ____ Yes ____ No
If yes, how frequent? ____ social only ____ several times per week ____ everyday

Do you or have you used illicit drugs? ____ Yes ____ No
If yes, what kind? ____ IV drugs ____ Pilks ____ Marijuana ____ Other: _____

Sports participation: ____ Yes ____ No
If yes, what sports? ____ Golf ____ Tennis ____ Football ____ Soccer ____ Baseball ____ Basketball ____ Running
List any other sports you play: _____

Please circle any of the following symptoms that you have experienced lately:

Constitutional	Fever	Nigh Sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Throat	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pains	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomitting	Diarrhea
Genitourinary	Burning w/ urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psyshiatric	Depression	Panic Attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy Eyes

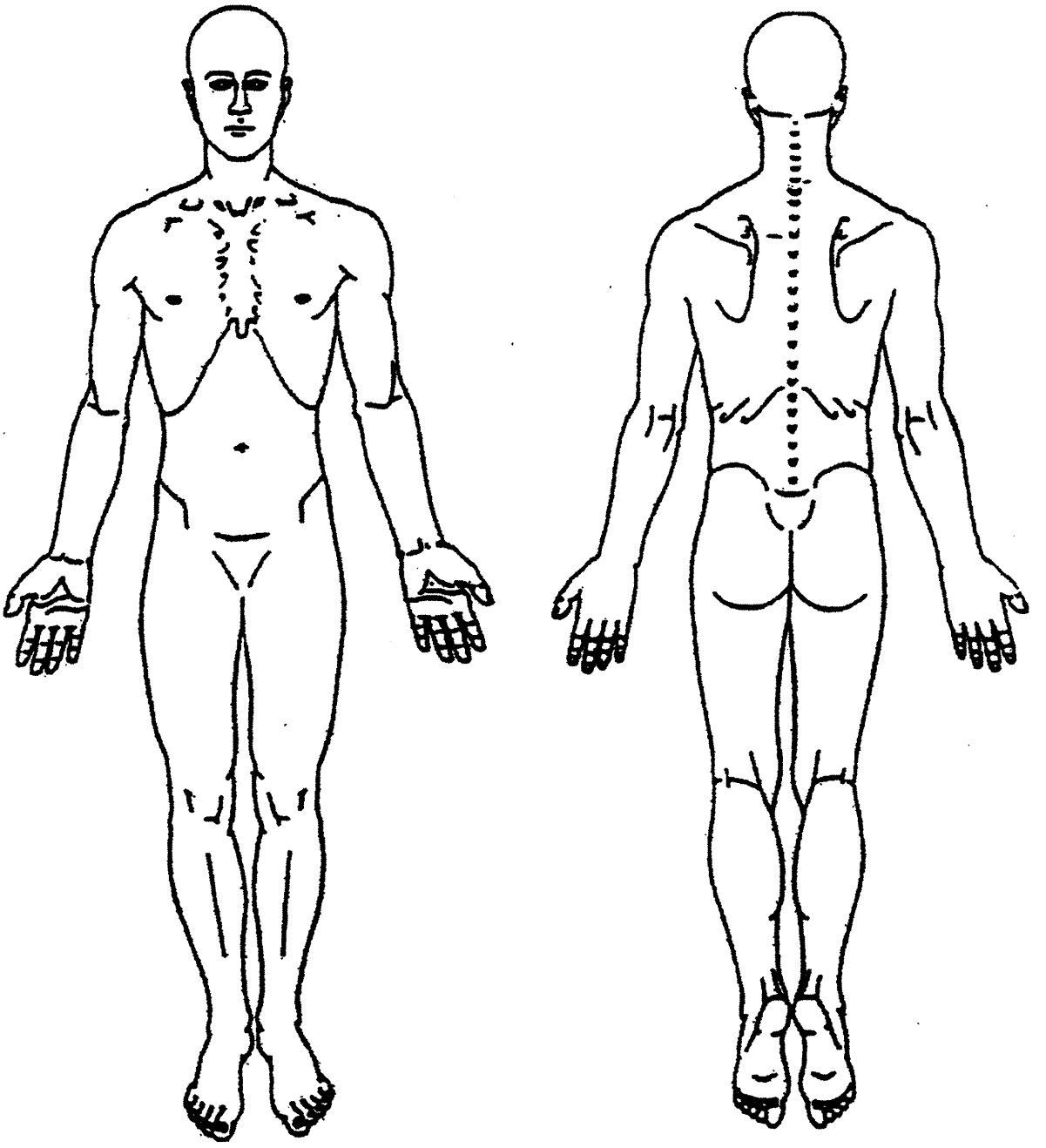
Patient Signature: _____ **Date:** _____

Reviewed by Physician: _____ **Date:** _____

Pain Diagram

Please mark below what symptoms you are having in the corresponding place on the body.

P= Achy Pain N= Numbness B= Burning S= Sharp Pain T= Tingling



Please Circle (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Patient Signature: _____ Date: _____

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SPINE & SPORTS REHAB

PRIVACY NOTICE

Your Information, Your Rights, Our Responsibilities

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

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act on your behalf
- File a complaint if you believe your privacy rights have been violated

Your Choices: You have some choices in the way we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services

Our Uses and Disclosures:

Thrive Spine and Sports Rehab, LLC/Thrive Point, LLC may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

Patient Signature: _____ Date: _____

THRIVE
SPINE & SPORTS REHAB

Financial Policy Agreement/Assignment of Benefits

Thank you for choosing *Thrive Spine and Sports Rehab, LLC/Thrive Point, LLC* as your healthcare provider. We are always striving to provide optimal care to all our patients and we will always do everything we can to achieve this goal.

Thrive Spine and Sports Rehab, LLC/Thrive Point, LLC is a private professional entity that is ***not*** contracted with any insurance plans with the exception of Medicare. Even though we are not a participating provider in your insurance plan's network, we pledge to help you understand and manage the financial aspects associated with providing you the best care possible.

Most insurance plans allow patients to select their own treating physician even if that physician is not contracted with their insurance plan's network. To help you understand your responsibilities, we will contact your insurance to gather information regarding your out-of-network coverage, and explain what financial obligations you will have for our services.

Due to the fact that we are an out-of-network facility your treatment plan will not be limited by what an insurance company plan representative will approve, but it will be determined by the recommendation made by one of our board certified practitioners with the sole intent of improving your way of life.

All charges will be submitted to your insurance company on your behalf as an out-of-network provider. You may be responsible for your deductible and co-insurance on allowed payments up to your out-of-network maximum according to your plan' out-of-network plan's coverage. Most insurance plans allow reasonable and customary payment for services rendered at *Thrive Spine and Sports Rehab, LLC/Thrive Point, LLC*, in which case you will not receive any bills. In a few cases, however, your plan may not provide reasonable and customary payments for services rendered, and in that case you may be responsible for some of the difference between what is billed and what your insuranvelan allows for payment.

In addition, some insurance companies may send payment for services directly to you. You agree to relinquish all payments that you receive from your insurance company for services rendered at *Thrive Spine and Sports Rehab, LLC/Thrive Point, LLC*. Failure to do so will result in legal action.

Initials: _____

Assignment of Benefits

Patient Name: _____

I irrevocably assign to *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC* all my rights and benefits under any insurance contracts for payment for services rendered to me by *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC.* I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC* to be released to *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC.* I irrevocably authorize *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC* to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC.* I irrevocably authorize *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC*, to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature: _____ Date: _____

INFORMED CONSENT FOR ACUPUNCTURE

I, _____, hereby authorize he Licenced Acupuncturistat *THRIVE SPINE AND SPORTS REHAB, LLC/THRIVE POINT, LLC* to administer any type of Oriental Medicine relevant to my diagnosis and treatment including by not limited to the following:

- Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- A massage technique called "gua sha" may produce redness on the skin which remains for 1-5 days. A slight bruising or tenderness may persist following the treatment.
- Cupping may be used to promote blood circulation through the body. Cups may produce a red/purple color on the area cupped which may remain for 1-5 days.
- Electrical stimulation may be used which produces a vibration/tapping sensation on the needles.
- Infrared heat may be applied to an area to help promote blood flow. This can cause redness in an area.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with treatment, and was given the opportunity to ask questions about my treatment. Although acupuncture is a safe modality and side effects are rare, I understand there is always a possibility of unexpected complications and no guarantee can be made concerning the results of the treatment.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

PATIENT NAME: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much like you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

** Spinal manipulative therapy
** Vital signs
** Orthopedic testing
** Muscle strength testing
** Radiographic studies
** Palpation
** Range of motion testing
** Basic neurological testing
** Postural analysis testing

The risks inherent in adjustments

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and/or X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and/or physical therapist and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

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APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to *THRIVE SPINE AND SPORTS REHAB/THRIVE POINT*. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment, please contact our offices as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective January 1, 2022 any patient who fails to show or cancels/reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a "No Show" and charges a $25.00 fee.

- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office night.

- As a courtesy, you do receive reminder texts for appointments. If you do not receive a reminder message, the above policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience circumstances please contact our Office Manager, who may be able to waive the No Show fee. Messages left at either location are acceptable.

I have read and understand the *Medical Appointment Cancellation/No Show Policy* and agree to its terms.

Patient Signature: _____ Date: _____