WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City_____ State_____ Zip____

Phone # (C)_____ (H) _____ (Other) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Occupation: _____ Employer: _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

HOW DID YOU HEAR ABOUT US?_____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Provider Information: (Please fill in your providers names if applicable)

Primary Care Physician:_____

Neurologist: _____

Podiatrist: _____

SIGNATURE (X) _____ **DATE** _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _FOX INTEGRATED HEALTHCARE as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby irrevocably assign my rights to payment, from any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby irrevocably assign the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby irrevocably assign to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 ____.

X_____
(patient signature)

_____
(please print patient name)

X_____
(signature of Guardian if applicable)

As courtesy, Fox Integrated Healthcare will bill major medical or personal injury insurances for services rendered and covered. **However, benefits are not guaranteed and therefore any circumstance that insurance does not cover, FIH patient is liable.** You may receive correspondence from your health insurance regarding services billed from FIH. If patient does not respond or reply in a timely manner, there is a possibility that these services may be denied by your insurance, resulting in patient responsibility. FIH will assist patient and or explain correspondence should that be necessary. Please be aware that insurance companies change policies without notice to patient.

X_____ _____
Signature of Patient Date

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I understand that there is no guarantee of results, as results do vary from patient to patient.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of the Notice of Privacy Practices of FOX INTEGRATED HEALTHCARE (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Witness (Office Staff) Date

Medical Intake Form

Please list all medications

_____

_____

Please list prior treatments for your current or chronic health concern

_____

_____

Were the prior treatments successful in the management of your health?

_____

Do you have any drug or latex allergies? _____

Please list all surgeries

_____

_____

Please list all medical problems (cancer, infection, high blood pressure, diabetes, thyroid etc.)

_____

_____

Do you have any implanted devices? (Pacemaker, defibrillator, etc.)_____

Do you have any history of a blood clot/DVT/pulmonary embolism/stroke?_____

Do you have cardia arrhythmia?_____

Do you have a history of epilepsy or seizures?_____

Please list any significant family medical history_____

_____

_____

What is your area of concern?_____

Does it radiate to anywhere else?_____

When did you start feeling this?_____

Is there anything that helps?_____

Is there anything that makes it worse?_____

Please rate the following

Pain 1 2 3 4 5 6 7 8 9 10

Burning 1 2 3 4 5 6 7 8 9 10

Numbness 1 2 3 4 5 6 7 8 9 10

Tingling 1 2 3 4 5 6 7 8 9 10

Tightness 1 2 3 4 5 6 7 8 9 10

Do you use tobacco? If so, how much? _____

Do you drink alcohol? If so, how much?_____

Do you use any drugs or marijuana? If so, how much? _____

REVIEW OF SYSTEMS

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Const. (Health in General) ❑ No Problems
Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems
Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other: _____

CV (Heart & Blood Vessels) ❑ No Problems
Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: _____

Resp. (Lungs & Breathing) ❑ No Problems
Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: _____

GI/GU (bowel and bladder) ❑ No Problems
Bowel or bladder incontinence
Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems
Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: _____

Neurologic (Brain & Nerves) ❑ No Problems
Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems
Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: _____

Do you have any other symptoms, history, or concerns that we should know about to take care of you?_____