●6209 S. Old Village Place ● Sioux Falls, SD 57108 ●101 S Philips Ave Suite 014 ● Sioux Falls, SD 57104 ●170 N Main Ave ● Parker, SD 57053
●605.271.8277 ● www.beactiveinc.com

PATIENT INTRODUCTION AND INSURANCE

Today's Date: ________________________

Last Name:	**MI:**	**First Name:**
Home Address:	City:	State: Zip:
Date Birth: Age:	Tel. Home:	Tel. Work:
Height: Weight:	Cell Number:	
Employer's Name:	Email:	
Occupation:	Marital Status (Circle): Single, Married, Domestic Partner, Divorced, Widowed	

MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes, ☐ No If yes, we need a copy of the card
Are you the insured person or dependent (wife/husband/child)?	☐ Insured, ☐ Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: ____________________________________ Insured Date of Birth: _______________________________________ Name of Insured Employer:___________________________________
What is your co-payment amount for each visit?	Amount: $ Percentage: %
Do you have a health insurance deductible for chiropractic?	☐ Yes, ☐ No Have you met deductible yet? What is your deductible $ ___________
If known, what are your chiropractic health insurance benefits annually?	Number visits per year #_____. Amount per year: $_______

Name and Telephone Number of your nearest adult emergency contact ____

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY AND WE WILL ASSIST YOU WITH YOUR INSURANCE CLAIM. HOWEVER, IT IS ULTIMATELY THE PATIENT'S RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN AND ELIGIBILITY. WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS. PLEASE SIGN BELOW.

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, coinsurance, and/or any other balances not paid by my medical insurance carrier.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 160, 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how a patient's protected health information (PHI) may be used and what said office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted in ActiveSpine office.

☐ **LEGAL GUARDIAN/PARENT NAME/RELATIONSHIP: ____**

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GENERAL HEALTH HISTORY (Page 1)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
□	History of poor healing or told that you have a healing disorder?	□	□
□	Smoke cigarettes or use tobacco products?	□	□
□	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	□	□
□	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	□	□
□	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	□	□
□	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	□	□
□	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	□	□
□	Epilepsy-Seizure-Convulsion history or any other neurological disease?	□	□
□	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	□	□
□	Cancer history or cancer treatment or surgery of any type?	□	□
□	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	□	□
□	Have you ever been hospitalized? Why/When:	□	□
□	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	□	□
□	Hypertension or high blood pressure? If yes, name of MD seeing:	□	□
□	Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?	□	□
□	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	□
□	**Women only**: Check box to left if there any chance that you are currently pregnant		

If you checked yes, please describe:

□ No, □ Yes **Do you have an infection, cold, virus, or other recent illness? Describe:** _________________________

HAVE YOU HAD ANY PREVIOUS SURGERIES?

□ **NO. (Check box if you never had any surgical procedure).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

FAMILY HISTORY?

□ No, □ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, or other diseases?

If yes, please describe:

MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

□ No, □ Yes **Are you taking any medications currently?** In yes, list all medications that you are taking:

□ No, □ Yes**. Have you taken any pain medications today? If yes, describe:** _________________________

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GENERAL HEALTH HISTORY (Page 2)

FOOD OR MEDICATION ALLERGY HISTORY

□ No, □ Yes . Do you have allergies to any medications, foods, shellfish, seafood, etc? If yes, List:

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your health and wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my health	**I feel worried about my health**	**I have constant concerns that affect my health**	**I have health challenges that affect me on a daily basis**	**I have some minor complaints about my health**	**I feel okay about my health with no complaints**	**I feel good most days**	**I feel well on a daily basis**	**I feel energetic and healthy**	**I feel active, energetic and fit**	**I feel great and am proactive about my health**

1. What number best describes how you feel about your health today?________
2. What number health goal do you want to achieve?___________

YES	NO	SLEEPING PATTERNS
□	□	Do you sleep poorly at night? How many hours of sleep do you get average?
□	□	Do you sleep on your stomach?
□	□	Do you consistently feel extremely tired when you wake up in the morning?

DO YOU TAKE SUPPLEMENTS?

□ No, □ Yes If yes, List: AND REASON

In commitment to your health, our office provides our patients a resource for education, science, and wellness support. Would you be interested in a complementary Health Coaching Session with one of our personal health coaches to discuss your goals and to develop a personalized action plan?
□Yes □No

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MUSCULOSKELETAL QUESTIONNAIRE

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES	NO	GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)
□	□	Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
□	□	Told that you have a bulging/herniated disc or disc degeneration in the spine?
□	□	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
□	□	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
□	□	Have you had a previous head injury in the past (e.g., blow or fall)?
□	□	Have you injured your neck, back, sacrum or pelvis in the past?
□	□	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
□	□	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

GENERAL EXTREMITY (SHOULDER, ELBOW, HAND, HIP, KNEE, FOOT)

YES	NO	Previous injury of significance to:
□	□	Shoulder if so, □L □R , When:
□	□	Elbow if so, □L □R , When:
□	□	Wrist if so, □L □R , When:
□	□	Hand if so, □L □R , When:
□	□	Hip if so, □L □R , When:
□	□	Knee if so, □L □R , When:
□	□	Ankle if so, □L □R , When:
□	□	Foot if so, □L □R , When:

PREVIOUS TREATMENT FOR CURRENT COMPLAINT?

□ No, □ Yes Have you seen an MD for your condition? Doctors name:_________________________________

□ No, □ Yes Have you ever been to a Chiro/PT for your condition? Chiro/PT name?__________

□ No, □ Yes Do you have imaging for your condition? □Xray □MRI □CT □Bone Scan □US

If so, what were the findings?____

□ No, □ Yes Would you like us to send your health records and documentation to your Primary Care Condition?

Indicate when you have your last physical examination by a medical doctor and please indicate his/her name?	Doctor: Date:

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INFORMED CONSENT

I hereby consent to the performance of chiropractic and/or physical therapy procedures, on myself, (or on the patient named below, for whom I am legally responsible) by ActiveSpine and/or other licensed DC/PT's who now or in the future provide chiropractic or physical therapy treatment for me. This consent includes other DC/PT's that are employed by ActiveSpine, whether or not their names are listed on this form.

I understand and consent to the following procedures:

☑ Examination	☑Mobilization	☑Nutrition therapy
☑ Adjustments	☑ IASTM Therapy	☑Taping
☑ Acupuncture	☑Myotherapy	☑Exercise

I understand that certain levels of exposure may be required to adequately examine and treat my symptoms. I understand that I will also be asked for verbal consent prior to any exposure taking place.

I have had an opportunity to discuss with the team at ActiveSpine the various types of treatment, that have been proposed to me for my condition, and the purpose and objectives of these chiropractic or physical therapy procedures. I understand that the results from the chiropractic or physical therapy treatment are not guaranteed for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic or physical therapy treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

To better suit your healthcare team, do you want us to send your medical records to your Primary Care Provider or the referring Physician? ☐ Yes ☐ No

If so, which Physician and Hospital?

Dr Hospital

____ ____________________

____ ____________________

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian I hereby authorize treatment for the following:

____________________________________ DOB ___________________

Patient's Full Name

To any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of ______________ and expires _______________

Signature __________________________________ Witnessed By________________________________

Patient Name:____________________ Date:_______________

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ACKNOWLEDGEMENT AND UNDERSTANDING

Please place CHECK MARK BY each item below

1. __________ I hereby authorize ActiveSpine to provide Chiropractic and Physical Therapy services for me.

2. __________ I authorize ActiveSpine to bill my insurance for me.
   I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by ActiveSpine.

3. __________ If this account is assigned to an attorney for collection and /or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. __________ I understand that if I am 15 or more minutes late to an appointment; that appointment will be rescheduled. A $40.00 fee will be charged for the missed appointment.

5. __________ I understand that a 24 hour notice is required for appointment cancellation. If the required notice is not given you will be responsible for the $40.00 cost of the missed appointment.

6. __________ I understand that for anyone who chooses to pay in full at the time of service and ActiveSpine does not bill insurance, a 20% discount will be given. All procedures billed accordingly. 1st visit ~ $120 depending on time and procedures. Follow up visits ~ $85 depending on time and procedures. I understand that Acupuncture and Dry Needling is an additional fee.

7. _________ I understand and authorize that if I have an outstanding balance, after a period of 3 billing cycles and payments are not made, or payment arrangements made, the credit card on file will be charged to satisfy my account.

8. _________In effort to conserve paper, I authorize electronic via secure email of my statement and account balance to the email address provided.

Dated ____________ day of _____________________ 20_____

Patient Signature____

Guarantor Signature____

Guarantor's Relationship to Patient____

Who may we thank for your referral?

Dr. ___________________________ Social Media

Friend_________________________ Co-Worker_____________________

Other_________________________

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CURRENT COMPLAINT

DESCRIBE THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury)

SEVERITY OF SYMPTOMS: 0-(NO PAIN/SYMPTOMS)-------10(MOST INTENSE PAIN/SYMPTOMS IMAGINABLE)

▢0 ▢1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8 ▢9 ▢1 0

WHAT CAUSED YOUR SYMPTOMS: ▢ PROGRESSIVE ▢UNKNOWN

DATE OF ONSET OR APPROXIMATE:

▢NUMBER OF ▢DAYS ▢MONTHS ▢YEARS

FREQUENCY OF SYMPTOMS:

▢0-25% ▢26-50% ▢51-75% ▢76-100% OF THE ▢DAYS ▢WEEK ▢MONTH

WHEN ARE THE SYMPTOMS WORSE:

▢MORNING ▢AFTERNOON ▢EVENING ▢PROGRESSES THRU THE DAY ▢IMPROVES THRU THE DAY

QUALITY OF SYMPTOMS:

▢DULL ▢SHARP ▢THROBBING ▢BURNING ▢DEEP ▢ACHING

▢TINGLING ▢STABBING ▢CRAMPING ▢NUMBNESS ▢RADIATING ▢STIFFNESS

AGGRAVATING FACTORS:

▢SITTING ▢STANDING ▢WALKING ▢BENDING ▢STOOPING ▢LIFTING

▢SLEEPING ▢SNEEZING ▢COUGHING ▢STRAINING ▢REACHING ▢TWISTING

▢LOOKING UP ▢LOOKING DOWN ▢MOVEMENT ▢REST ▢LYING SUPINE ▢DRIVING

▢TYPING ▢SCOOPING ▢HOUSE CHORES ▢EXERCISE ▢LYING PRONE ▢STAIR STEPPING

RELIEVING FACTORS:

▢SITTING ▢STANDING ▢LYING ▢KNEES BENT UP ▢SUPPORT

▢NO MOVEMENT ▢MOVEMENT ▢HEAT ▢ICE ▢ANALGESIC TOPICAL

▢IBUPROFEN ▢MEDICATION ▢REST ▢STRETCHING/EXERCISE ▢ADJUSTMENTS

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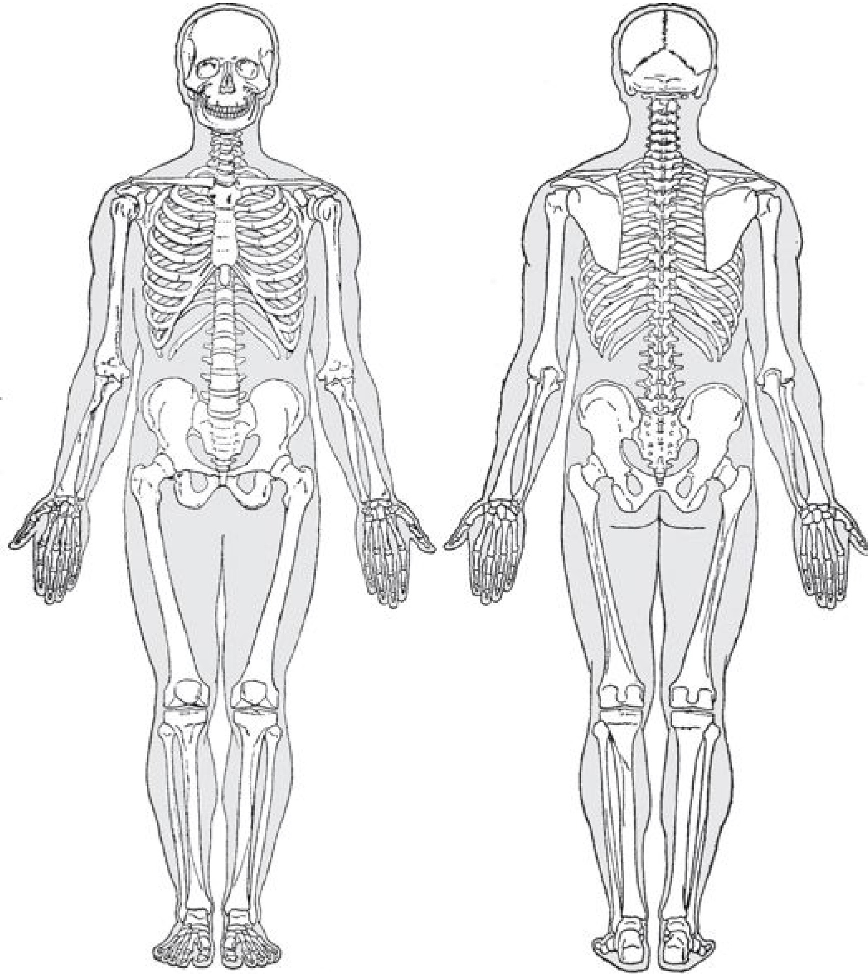
DRAWING OF COMPLAINTS

Please use the letters below to indicate the type and location of your symptoms right now.

A=ACHE B=BURNING S=SHARP ST=STIFF P=PINS/NEEDLES N=NUMB/ELECTRIC



OFFICE-ONLY

NUMBNESS/ TINGLING
TEMPERATURE DISCREPANCIES
DIFFICULTIES BREATHING
HEADACHES
SADDLE PARAESTHESIA's

BOWEL/BLADDER CHANGES
LIGHT HEADEDNESS/DIZZINESS
CHEST PAINS
FEVER/FLU LIKE SYMPTOMS
VISUAL/AUDITORY CHANGES

NIGHT PAIN
UNEXPLAINED WT LOSS
EXCESSIVE FATIGUE
URINARY PAIN

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NOTICE OF DOCTOR'S PRIVACY PRACTICE (WITH EMPLOYEES-STAFF)

The ActiveSpine offices, is required by the Health Insurance Portability and Accountability Act (HIPAA) to inform all patients about the recent Federal/State standards that have been adopted to protect the privacy and confidentiality of all patients' identifiable and protected health information (PHI). Our office has certain responsibilities to the patient that are outlined in this notice. This notice describes the various rights that patients have regarding PHI. If the patient desires a copy of this notice, our office will provide one, upon request (45 CFR Sect 164)

PATIENTS **RIGHTS REGARDING HEALTH-MEDICAL RECORDS**

All medical records, including those that the patient, doctor(s), nurses, therapists, laboratory technicians, and staff generate, including intake forms, history, examination, diagnosis, treatment, progress notes, therapy, testing, etc., as well as any records received from other sources become the property of this facility. The patient has the right to inspect and copy his/her health records, amend or change his/her records, and request restrictions on certain aspects of his/her medical records for a period of seven years or as long as the patient's records are maintained by this facility. If the patient has any sensitive PHI information he/she wants "restricted," the patient may request that the PHI be "restricted" unless specifically authorized by the patient or when mandated by a legal or court order. If the patient provides sensitive information (such as psychotherapy, domestic violence, AIDS/HIV, communicable disease, elder abuse, drug-alcohol abuse, mental impairment, and etc) these require special authorization for release of records to other parties. The patient may ask for an accounting for every disclosure and use of his/her PHI to another party at any time. The patient may ask that disclosure of his/her PHI be communicated in a different manner, such as by fax instead of by postal service. Our office will not disclose any PHI without the patient's signed and dated authorization, unless mandated by law (such as a court order), in an emergency situation, when providing treatment to the patient based on prescribed orders from another health care provider, or when compelled to do so in cases of potential harm/injury to a person, abuse, or crime as dictated by law. The patient may revoke any authorization, except in situations where actions or reliance upon have already been taken. All requests for amendments, viewing or copying records, restrictions, revocation of authorizations, or request for summary of disclosures or uses of patient records must be submitted in writing to the privacy officer. Please give our office enough time to process any requests. If requesting records, HIPAA laws allow for 30 days if records are maintained on-site and 60 days if stored off-site.

WHAT ARE OUR RESPONSIBILITIES TO THE PATIENT?

Our offices are required to maintain reasonable and appropriate administrative, technical, and physical safeguards to insure the integrity and confidentiality of patient's PHI and protect against unauthorized uses or disclosures of the PHI. Our office is required to allow the patient to indicate alternative means of communication from our office, including preferred address locations for mail and alternative telephone numbers for receiving calls or for leaving messages. Any person/business who has access to, or needs disclosure of a patient's PHI in order to perform necessary tasks, (examples include computer, technical, billing, janitorial, physician, diagnostic, laboratory, or radiology services) will be required to sign a "Business Associate" agreement that require appropriate safeguarding of PHI. Our office reserves the right to change our practices and make new provisions or disclosures. Our office will make every reasonable effort to comply with protecting the patient's PHI and if the health information practices of our office change, the patient will be mailed a copy of such changes to the most recent address given by the patient.

HOW WILL OUR OFFICE USE YOUR PROTECTED HEALTH INFORMATION?

This office has several doctors, therapists, assistants, and other personnel that work as a team to provide the patient with the best care in a coordinated effort. Your medical-health records that are generated each visit provide the basis for our office to determine your diagnosis, what treatment needs to be prescribed or modified, how you have responded to treatment, whether consultation/referral is needed, and provides the means for the doctors/staff to communicate relevant PHI with each other. Unless restricted by the patient, our office will use the patient's PHI to coordinate care and to obtain information to verify and process insurance billing, provide "minimum necessity" records to those third-party payers who are responsible to pay for services given, and to obtain authorization for treatment, services, procedures, testing, and for supplies provided. The patient's PHI will be used to help determine the condition, diagnosis, treatment, and the need for consultation, referral, testing, or coordination with other health care providers. The patient's PHI may be used to respond to questions from insurance companies regarding the necessity of a service, test, or supplies or to verify services. Our office will use the patient's PHI to return telephone calls, make appointment reminders, mail billing statements or updates, and for sending other office related material. For cases in which the patient has an attorney, our office needs to be able to communicate about various aspects of the patient's case and submit reports outlining the patient's response to treatment, diagnosis, and other relevant issues. If the patient has a friend, family member, or other person in attendance at our office, the patient must provide signed consent for any discussions that involve any PHI. If the patient's doctor is out of the office and has another doctor covering his/her practice, the patient's PHI is necessary for the doctor to provide treatment.

NOTE**:** Patients are encouraged to mail written recommendations or file complaints directly to the office address above with ATTN: PRIVACY OFFICER on envelope. If the patient believes that the health care provider has violated his/her privacy rights he/she may file complaints with the U.S. Department of Health and Human Services at 200 Independence Ave, SW, Room 509F, HHH Bldg, Washington, DC 20201. Our office will not retaliate in any manner if any complaints are made. Thank you.