●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 UPDATE FORM

Today's Date: ________________________

ANY CHANGES IN:

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

ANY CHANGES IN:

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 FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, 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, co-insurance, 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)

HAVE YOU HAD NEW INJURY OR MUSCULOSKELETAL PAIN SINCE LAST APPOINTMENT?

□ **NO. (Check box if you have no prior history of previous injury or pain)** If yes, please describe below:

HAVE YOU HAD ANY RECENT FRACTURES/BROKEN BONES

□ **NO. (Check box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU HAD ANY SURGERIES SINCE LAST APPOINTMENT?

□ **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:

MEDICATION CHANGES (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: _________________________**

ARE YOU TAKING SUPPLEMENTS?

□ No, □ Yes If yes, List: AND REASON

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ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial 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 DryNeedling 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____

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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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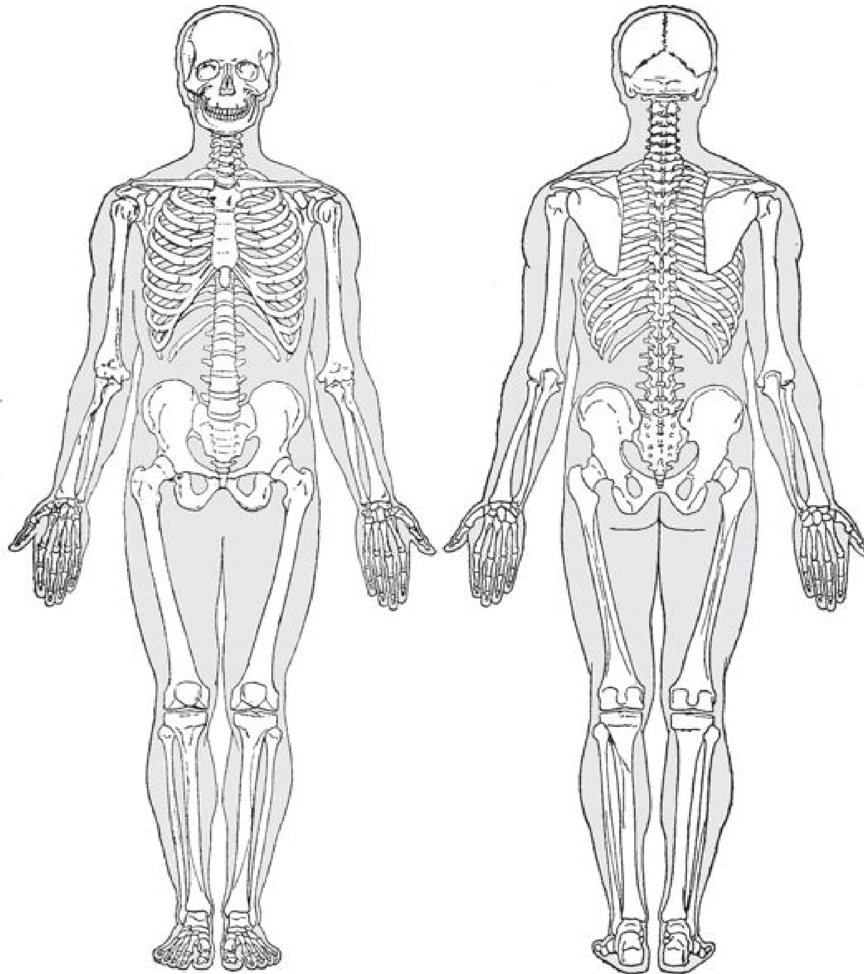
DRAWING OF COMPLAINTS

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