

Today's Date: _____

Patient Information

Name (First, Middle, Last): _____ Date of Birth: _____ Age: _____

Address: _____ City, State, Zip: _____

Sex: M F Marital Status: Single Married Widowed Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Name: _____ Email: _____

Employment Status: Employed Full-time Part-time Student Full-time Student Other

Weight _____ Height: _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Responsible Party (if different from above)

Name (First, Middle, Last): _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security#: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ SS#: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID #: _____

Occupation: _____ Employer: _____ Employer Ph #: _____

Address: _____ City, State, Zip: _____

Spouse Information

Name (First, Middle, Last): _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security#: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of an Emergency

Name (First, Middle, Last): _____ Phone: _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Is Your Illness or Injury Related

Employment Emergency Accident (Other) Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? Yes No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

By An Attorney By a Doctor Print Ad Online Directory Search Engine Marketing Event

Please Specify Source Here: _____

Are you involved in any kind of litigation due to your condition? Yes No

Medical/Family History

S=Self, M=Mother, F=Father

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Have you been treated by a physician for any health condition in the last year? No Yes

Describe Condition: _____ Date of Last Physical Exam: _____

Primary Doctor's Name: _____ Phone: _____

SURGICAL HISTORY:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____

ACCIDENT HISTORY: Job Auto Other 1. _____ **Date:** _____

Job Auto Other 2. _____ **Date:** _____

Job Auto Other 3. _____ **Date:** _____

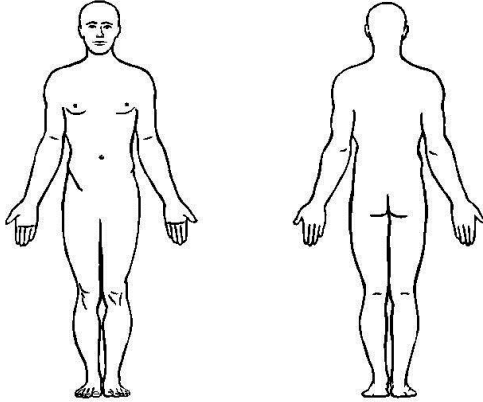
PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1-10, with 1 being very minimal and 10 being the worst you can imagine)

1. _____ **Pain Scale #** _____
2. _____ **Pain Scale #** _____
3. _____ **Pain Scale #** _____
4. _____ **Pain Scale #** _____

Please circle and mark the areas of concern on the diagram below.

N=Numbness T=Tingling P=Pain W=Weakness B=Burning A=Ache



Symptoms are worse in the: Morning Afternoon Night

When and how did it occur? _____

Symptoms developed from: Job Related Injury Auto Accident Other Accident Illness

Symptoms have persisted for # _____ Hour(s) _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s) _____

Have you ever had this before: No Yes If Yes, when? _____

If you were to guess, what do you think is causing your complaint(s)?

Name and location of doctors previously seen for present condition(s):

Are you pregnant? No Yes Date of last menstrual period (onset): _____

Have you ever used tobacco? Never Previously Daily Weekly Monthly Yearly

Please check the following activities that aggravate your condition:

Bending Lifting Lying down Reaching Sitting Standing Straining with bowel movement
 Turning head Walking Other _____

Please check the following activities that relieve your condition:

Bending Lifting Lying Down Reaching Sitting Standing Turning Head Walking
 Other _____

Please check any additional symptoms you may be experiencing:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Numbness (fingers) |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Tremors | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Muscles jerking | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Pins and needles (arms) | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Concentration loss/confusion | | <input type="checkbox"/> Frequent colds | |



HIPPA NOTICE, INFORMED CONSENT, PHOTO RELEASE

HIPAA Notice:

I understand and agree to allow Natural Balance LLC to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policy and procedures concerning the privacy of your Patient Health Information, please let the desk staff know you would like the full HIPAA Notice before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: (parent if minor) _____ **Date:** _____

Informed Consent for Myofascial, Massage, or Physical Therapy Treatment:

I hereby request and consent to the performance of myofascial release, massage, advanced bodywork, manual therapy, or physical therapy by Natural Balance LLC and/or its employees. I understand and am informed that, with the practice of myofascial release, massage, advanced bodywork, manual therapy, or physical therapy there are some risks to treatment, including but not limited to soreness, and stiffness of muscles and related tissue. I understand that I must inform the practitioner of any possibility of pregnancy at any point during the treatment process.

Patient's Signature: (parent if minor) _____ **Date:** _____

Consent To Be Photographed for Postural Assessment

I _____ consent to be photographed, for the purpose of postural assessment by Natural Balance LLC. I understand that only the healthcare professionals employed by Natural Balance will view the photos taken for postural assessment. The photos will not be used for any other purpose by Natural Balance or for public display. If you consent to the photos being taken for this assessment please sign below.

I _____ have read and understand the information provided.

I _____ give my permission to be a part of the recording and for the use of that recording as assessment based upon the conditions outlined above.

Patient signature: _____ **Date** _____

Parent Signature (if patient is a minor): _____ **Date** _____



PATIENT FINANCIAL RESPONSIBILITY and INSURANCE RELEASE

Please indicate how you would like to satisfy your financial responsibility for treatment. Read carefully and initial your selection below.

_____ **1. PURCHASE DISCOUNTED PACKAGE(S)**

- Includes 5-pack, 10-pack, Silvercare, or other value package offered
- **Available Documentation:** Proof of payment receipt only

_____ **2. SELF-FILE WITH MY INSURANCE**

- I will pay full per session price for my treatment each visit
- **Available Documentation:** Invoice with insurance codes
- I understand that to receive reimbursement from any insurance company or federal/health savings accounts, I must file for these benefits myself

_____ **3. FILE WITH MY TRICARE, MEDICARE, OR HEALTHCHOICE INSURANCE** NBIC only files with these insurance plans on patient's behalf

- I agree to pay deductibles/co-pays/co-insurance at time of service, based on my insurance plan requirements and full per session price
- I understand that my insurance plan allowance or monies paid at time of service may not cover all charges and I am responsible for any charges not covered based on Natural Balance LLC's in network agreement with my insurance carrier.
- Chiropractic, Speech, Occupational, or other Physical Therapy during this calendar year may affect my insurance payments and I will be responsible for the difference
- **Available Documentation:** Claim details and account statement
- I authorize Natural Balance LLC to release to the insurance carrier any information needed for the payment of any claim
- I authorize Natural Balance LLC to be paid by my insurance carrier or third party payer

Patient's Signature: (parent if minor) _____ **Date:** _____

ALL PATIENTS

- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
- I authorize Natural Balance LLC to release any information including my diagnosis and records of any treatment or examination rendered to my child or me, to third party payers and/or health practitioners.
- I understand that I may request copies of my medical records at my own expense. This may include my intake form, therapist's notes, etc. Formal insurance PT notes are **only** provided with Option 3.
- A photocopy of this authorization is to be considered as valid as the original.
- I certify that I have read and understand all of the above information.

Patient's Signature: (parent if minor) _____ **Date:** _____



Cancellation and Missed Appointment Policy

Cancellation of an Appointment

Our therapists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be treated. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours.

As of November 1st, 2014 there will be a fee of \$25.00 fee assessed if we do not receive a call to cancel an appointment at least 24 hours in advance of the scheduled time.

How to Cancel Your Appointment

To cancel appointments, please call 405-541-1078. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

No Show Policy

A "no-show" is missing an appointment without canceling it. A failure to be present at the time of a scheduled appointment will be recorded in the your medical record as a "no-show".

- First Missed Appointment: A \$25.00 fee will be billed to your account.
- Second Missed Appointment: A \$25.00 fee will be billed to your account
- Third Missed Appointment: The full cash price of session will charged to your account and the patient may be discharged from the practice. We reserve the right discharge the patient after the third missed appointment whether they call in time or not.

Scheduled Appointments

We understand that delays can happen however we must try to keep our other patients on time. If you arrive the session will still end at the scheduled time.

If you are over 15 minutes late and are using your insurance we reserve the right to charge you for the portion of the session that cannot be billed to your insurance. This amount will be based on the cash price for the session. If you are paying cash you will still be charged the full price for the session.

If you are 15 minutes or more late on 3 or more occasions we reserve the right to discharge you completely from our practice.

I understand the above Cancellation and Missed Appointment policy.

Signature

Date