Natural Balance
INTEGRATIVE CARE

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: ____

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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

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dizziness	☐	☐	☐	Nervousness
☐	☐	☐	Anemia	☐	☐	☐	Earache	☐	☐	☐	Night Sweats
☐	☐	☐	Arthritis	☐	☐	☐	Epilepsy	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Fatigue	☐	☐	☐	Poor Circulation
☐	☐	☐	Back Pain	☐	☐	☐	Headaches	☐	☐	☐	Reproductive Trouble
☐	☐	☐	Bladder Trouble	☐	☐	☐	Heart Trouble	☐	☐	☐	Serious Injury
☐	☐	☐	Bone Fracture	☐	☐	☐	High Blood Pressure	☐	☐	☐	Sinus Trouble
☐	☐	☐	Bowel Control Loss	☐	☐	☐	HIV	☐	☐	☐	Spinal Curvature
☐	☐	☐	Cancer	☐	☐	☐	Indigestion	☐	☐	☐	Stroke
☐	☐	☐	Concussion	☐	☐	☐	Kidney Disorders	☐	☐	☐	Thyroid Problem
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Weakness
☐	☐	☐	Diabetes	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Weight Gain/Loss
☐	☐	☐	Dislocated Joints	☐	☐	☐	Neck Pain	☐	☐	☐	Other___________

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 #__________

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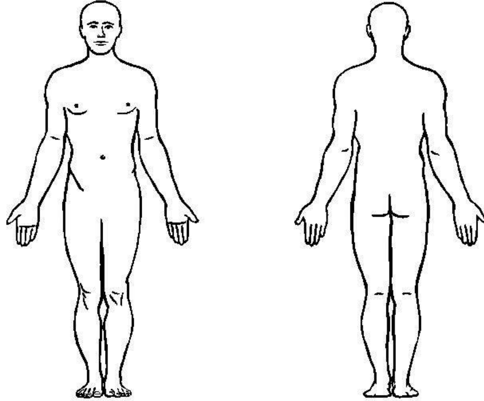
Please circle and mark the areas of concern on the diagram below.

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 releive your condition:
☐ Bending ☐ Lifiting ☐ Lying Down ☐ Reaching ☐ Sitting ☐ Standing ☐ Turning Head ☐ Walking
☐ Other______________________________

Please check any additional symptoms you may be experiencing:

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

Please list all medications, vitamins, and supplements you are currently using:

Name	Dosage (mg)	Frequency (i.e. daily, 2x/day, etc.)

Per Medicare and private insurance requirements please sign and date as to the accuracy of this information.

_______________________________ _______________________________

Signature **Date**

AUTHORIZATION - BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY RELEASE OF INFORMATION

I authorize ***Natural Balance*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***Natural Balance LLC*** from my insurance carrier or third party payer. I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between ***Natural Balance LLC*** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. 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 understand if I am treated by a Chiropractor, Speech Therapist, or another Physical Therapist while being treated at ***Natural Balance LLC*** or anytime within the same year this could decrease how much my insurance carrier will pay towards my care at ***Natural Balance LLC*** and I will be responsible for the difference.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such treatment to third party payers and/or health practitioners.

A photocopy of this authorization is to be considered as valid as the original.

Patient's Signature: (parent if minor)______________________________ Date:__________

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 your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is posted for you at each one our locations 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, or physical therapy by ***Natural Balance LLC*** and/or its employees. I understand and am informed that, as the practice of myofascial release, massage, 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: ___________

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

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 provide above.

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 __________

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Please Remember to Wear Appropriate Attire During MFR Sessions:

For Women: Loose fitting shorts, bra, sports bra, or bikini top.

For Men: Loose fitting shorts are acceptable

Thank-you NBIC Mgmt.