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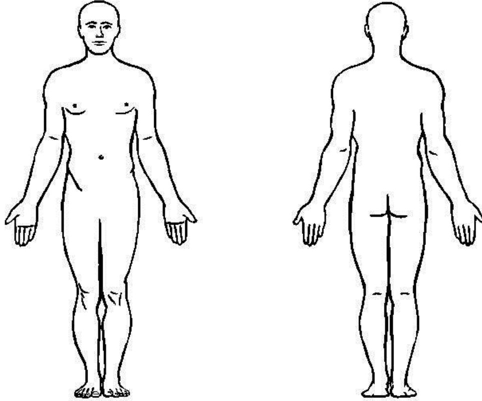
Please circle and mark the areas of concern on the diagram below.

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

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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**

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. ALL purchases for treatments, packages, and self care items (stretch equipment, oils, etc are **nonrefundable**.
- 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