Innovative Spine Rehab

A Member of Arkansas Family Care Network, P.A.

Is This Work or Accident Related?
Yes_____ No_____
Date of Injury_____

PATIENT INFORMATION
Print Clearly

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE
****A COPY OF YOUR INSURANCE CARD WILL NEED TO BE OBTAINED FOR OUR RECORDS****

PATIENT INFORMATION
First Name_____ M.I._____ Last Name_____
Address_____ Telephone_____
City_____ State_____ Zip_____

DOB_____ Race_____ Sex_____ SSN_____ Marital Status: **S M W D**
Cell Phone Number_____Email address _____

Occupation _____
Employer_____ Employer Telephone_____

INSURANCE INFORMATION
Primary Insurance Co_____ Effective Date_____
ID#_____ Group#_____

Secondary Insurance Co_____ Effective Date_____
ID#_____ Group#_____

REFERRING PHYSICIAN_____

****EMERGENCY**Please give name and telephone number of a friend or relative that *DOES NOT* live at your address**
NAME_____ TELEPHONE_____

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE THAT THE ARKANSAS FAMILY CARE NETWORK IS PAID FOR SERVICES RENDERED. THIS INCLUDES LIABILITY COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE INNOVATIVE SPINE REHAB TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT

(SIGNATURE) OF PATIENT OR GUARDIAN X_____

DATE_____

*If you are **not** the patient, please fill out the following information:*

Name:_____
Relationship to Patient: _____
Address: _____
Telephone: _____

Please furnish a copy of any conservator/guardianship papers with this form.

ARKANSAS FAMILY CARE NETWORK

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Arkansas Family Care Network's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Signature: _____ **Date: _____**

Print Name: _____ **Date of Birth: _____**

IF YOU WOULD LIKE SOMEONE ELSE TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION PLEASE FILL OUT INFORMATION BELOW:

I, _____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION:

1._____ 2._____

3._____ 4._____

CANCELLATION POLICY

Due to limitations on the schedule and the desire of many to get on the schedule, we have a new policy regarding cancellations. If you cancel or reschedule your appointment more than three (3) times, we may place you on a call-in only basis. What this means simply is that on the days that you know you have to come to therapy, then call us and we will work you in if we have space available. You will no longer be allowed to schedule days in advance, but on a day-to-day basis only. _____

NO SHOW POLICY

If you do not show for a scheduled appointment or fail to contact us and cancel within five (5) hours of your scheduled appointment, you will be charged thirty dollars ($30). Insurance does not cover this charge. _____

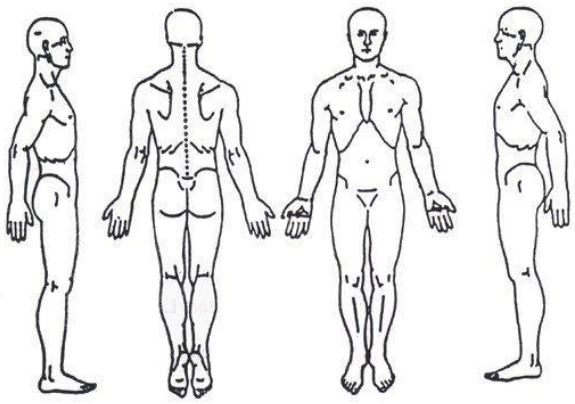
LATE POLICY

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient. _____

CELL PHONE POLICY

Cell phones must be shut off or silent. We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. _____

Draw where you have pain/symptoms:



How would you describe your pain?

__ Sharp __ Numb __ Dull __ Tingly
__ Stiff __ Diffuse __ Achy __ Burning
__ Shooting __ Electric __ Other _____

Current Pain:

best 1 2 3 4 5 6 7 8 9 10 worst

Pain in the past week:

best 1 2 3 4 5 6 7 8 9 10 worst

How would you describe your overall health?

__ Excellent __ Very Good __ Good __ Fair __ Poor

Who have you seen for your problem?

__ Chiropractor
__ ER Physician
__ Massage Therapist
__ Neurologist
__ Occupational Therapy
__ Orthopedic Physician
__ Pain Management Physician
__ Physical Therapist
__ Primary Care Physician
__ Other _____

How much has the problem interfered with your work?

__ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely

How much has the problem interfered with your social activity?

__ Not at all __A little bit __ Moderately __ Quite a bit __ Extremely

Briefly describe your symptoms _____

_____

How often do you experience your symptoms?

__ Constantly (76-100% of the time)
__ Frequently (51-75% of the time)
__ Occasionally (26-50% of the time)
__ Intermittently (1-25% of the time)

Current prescription medications_____

Current over the counter medications_____

Surgical procedures and year_____

Please check past/present health conditions

Past	Present		Past	Present		Past	Present	
__	__	Headaches	__	__	High Blood Pressure	__	__	Diabetes
__	__	Neck Pain	__	__	Heart Attack	__	__	Excessive Thirst
__	__	Upper Back Pain	__	__	Chest Pains	__	__	Frequent Urination
__	__	Mid Back Pain	__	__	Stroke	__	__	Smoking/Tobacco Use
__	__	Low Back Pain	__	__	Angina	__	__	Drug/Alcohol use
__	__	Shoulder Pain	__	__	Kidney Stones	__	__	Allergies
__	__	Elbow/Upper Arm Pain	__	__	Kidney Disorders	__	__	Depression
__	__	Wrist Pain	__	__	Bladder Infections	__	__	Systemic Lupus
__	__	Hand Pain	__	__	Painful Urination	__	__	Epilepsy
__	__	Hip Pain	__	__	Loss of Bladder Control	__	__	Dermatitis/Eczema
__	__	Upper Leg Pain	__	__	Prostate Problems	__	__	HIV/AIDS
__	__	Knee Pain	__	__	Abnormal Weight Gain/Loss	__	__	Birth Control Pills
__	__	Ankle/Foot Pain	__	__	Loss of Appetite	__	__	Hormone Replacement
__	__	Jaw Pain	__	__	Abdominal Pain	__	__	Pregnancy
__	__	Joint Pain/Stiffness	__	__	Ulcer	__	__	General Fatigue
__	__	Arthritis	__	__	Hepatitis	__	__	Muscular Incoordination
__	__	Rheumatoid Arthritis	__	__	Liver/Gall Bladder Disorder	__	__	Visual Disturbances
__	__	Cancer	__	__	Tumor	__	__	Dizziness
__	__	Asthma	__	__	Chronic Sinusitis	__	__	Other _____

Anything else pertinent to your visit today? _____

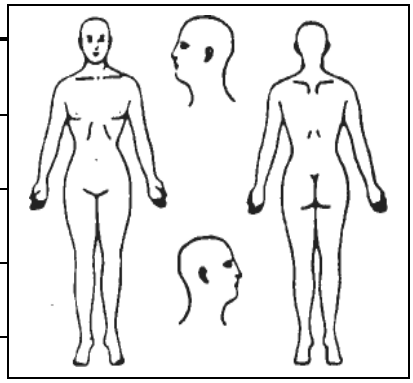
Innovative Spine Rehab of Arkansas, LLC

Daily Treatment and Progress Notes

Patient's Name_____Date_____Acct #_____
(Please print) last first

Please indicate precisely the area of your symptoms using "XXX" on the figures below

Progress Report _____



Since your last visit

Any NEW conditions? Yes No

New accident / injury? Yes No

Have you seen another doctor? Yes No

Have you missed work? Yes No

If you missed time from work are you still off? Yes No

Last date worked_____

Name your conditions in the spaces below:	**Please circle current pain level** Better ... Worse	**Compared to last Visit**		
1._____	0 1 2 3 4 5 6 7 8 9 10	Better	Same	Worse
2._____	0 1 2 3 4 5 6 7 8 9 10	Better	Same	Worse
3. _____	0 1 2 3 4 5 6 7 8 9 10	Better	Same	Worse

Patient's Signature_____

Please Do not write below this line

New Patient Evaluation	☐	Iontophoresis	☐	Gait Training	☐
Re-Evaluation	☐	Ultrasound	☐	Canalith Repositioning	☐
Hot/Cold Packs	☐	Exercises	☐	LSO Fitting	☐
Traction	☐	NMR	☐		
EMS Attended	☐	Manual Therapy	☐	MC701	
EMS Unattended	☐	Therapeutic Activity	☐	PT / PTA	