Willow Bend Sports & Spine Center

Improving Lives & Performance

New Patient Information / Change of Address

Date _____

New Patient _____ **Change of Address** _____

Patient Name _____

Date of Birth _____ **Age** _____

Gender (circle one) **MALE** **FEMALE**

Marital Status (circle one) **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

E-Mail _____

Address _____

City, State, Zip _____

Cell Ph #_____

Emergency Contact _____ **Ph#** _____

Primary Care Physician _____

Ph # _____

Referred By / How Did you Hear About Us?

_____

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name

NOTE: WBSSC will never sell your personal information or use it for solicitation purposes.

Willow Bend Sports & Spine Center Patient Intake Form

Name _____ **Date** _____

Date of Birth _____ **Phone#** _____

1. **What is the "main" reason for your visit today? (Please limit each visit to ONE area of treatment)** _____

   _____

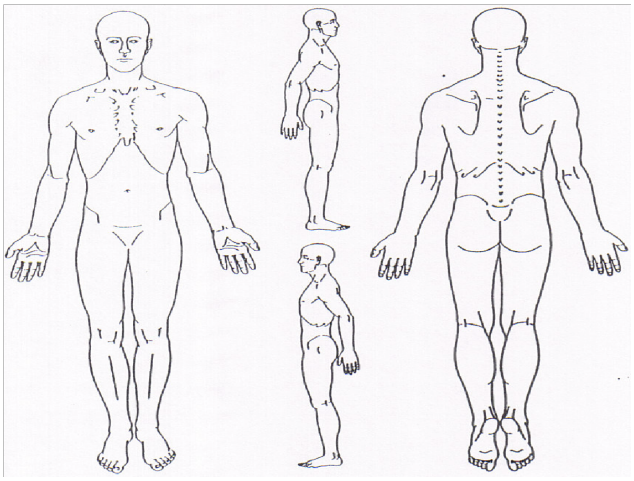
2. **Please circle the severity of your main complaint**

   (None) 0 1 2 3 4 5 6 7 8 9 (Severe)

3. **Please indicate your "overall" improvement of your condition since your initial visit.**

   No Change 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. **Using the diagram and symbols below, please indicate where you are experiencing your "main" complaint today**



A=Aching **B=Burning**
C=Cramping **D=Dull**
N=Numbness **S=Sharpness**
P=Pins/Needles **ST=Stabbing**
T=Tightness

^^^=Shooting **///=Throbbing**
+++=Tingling
O=Other: _____

5. **Please describe ALL details concerning your "main" complaint**

   _____

   _____

Willow Bend Sports & Spine Center
Patient History

Patient Medications
(Please Include Vitamins, Supplements and Herbs)

_____ _____

_____ _____

_____ _____

_____ _____

Previous and Current Medical Conditions
(Please Include Hospitalizations and Surgeries)

_____ _____

_____ _____

_____ _____

Patient Allergies
(Please List ALL Medicine and Food Allergies)

_____ _____

_____ _____

_____ _____

Patient Family History
(Please List Any Medical Conditions)

Father _____ **Mother** _____

_____ _____

Brother(s) _____ **Sister(s)** _____

_____ _____

Grandmother(s)_____ **Grandfather(s)**_____

_____ _____

Willow Bend Sports & Spine Center
Patient History (Continued)

Patient Current Symptoms and Past Care

(Please Circle Yes or No)

Does the pain wake you up at night?	Yes	No
Does the pain radiate from one region to another?	Yes	No
Do you have noticeable weakness in any region?	Yes	No
Do you have any bladder issues because of your condition?	Yes	No
Have you had an MRI, X-Ray, CT Scan, or Bone Scan for your condition(s) within the last year?	Yes	No

If yes, what is the name of the imaging facility? _____

Patient Social History

Patient Work History (circle one)

EMPLOYED UNEMPLOYED RETIRED HOMEMAKER STUDENT

Patient Occupation (Please describe the environment in which you work)

_____

_____

Alcohol	Yes	No	If yes, I have _____ drink(s) per day or _____ drink(s) per month.
Tobacco	Yes	No	If yes, I smoke _____ pack(s) per day or _____ pack(s) per month.
Illegal Drugs	Yes	No	If yes, what substance? _____

_____ _____

Signature of Patient or Legal Guardian **Date**

Willow Bend Sports & Spine Center
Treatment Fee Authorization

I understand, if recommended by Dr. Eidsvig, the following treatment fees will be added to the cost of my base treatment.

I understand I have the option to refuse this additional treatment.

_____ $50 Shock Wave Treatment
INITIAL HERE

_____ $30 Type IV Laser Treatment
INITIAL HERE

_____ _____

Signature of Patient or Legal Guardian **Date**

Willow Bend Sports & Spine Center
Patient HIPPA & Privacy Practices Authorization

Name _____

Consent for Treatment I hereby authorize the doctor(s) at Willow Bend Sports & Spine Center and their staff to perform diagnostic tests and provide the necessary treatment for chiropractic/medical and health care for the above-mentioned patient.

Patient Privacy Practices Willow Bend Sports & Spine Center is committed to ensuring your Protected Health Information (PHI), governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), remains confidential. All electronic and paper medical records are safeguarded and released only with your consent to your insurance carrier (should you file with your insurance provider), medical professionals directly involved with your care, or as required by law.

I have been informed of and given the opportunity to review and secure a copy of Willow Bend Sports & Spine Centers' Notice of Privacy Practices, containing a complete description of the uses and disclosures of my protected health information. I understand the Notice of Privacy Information serves as:

1. A basis for planning my care and treatment.
2. A means of communication amongst health care professionals who contribute to my care.
3. A source of information for applying diagnosis and surgical information to my bill.
4. A means by which a third-party payer can verify services billed were provided.
5. A tool for routine health care operations, such as assessing care quality and reviewing the competence of health care professionals.

I have read and understand the Patient Privacy Practices provided by Willow Bend Sports & Spine Center. I understand my personal health information will be used in treatment and to improve the quality of care.

I authorize the release of my "Medical Records/Privacy Information", which includes protected health information (PHI), any medical conditions and billing/financial information to be disclosed for purposes of communicating results, findings, and care decisions to the following individuals:

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

_____ _____

Signature or Patient or Legal Guardian **Date**

Willow Bend Sports & Spine Center
Office Policies

Name _____

Financial Responsibility I understand Willow Bend Sports & Spine Center is a self-pay provider, and payment in full is due at the time of service.

Insurance I understand Willow Bend Sports & Spine Center **is NOT "in-network"** with any insurance provider and **does not guarantee insurance reimbursement.** I understand, I will be furnished a detailed document of medical services performed during my appointment at checkout. I am aware it is **my responsibility to retain all receipts required** and **I am solely responsible for filing insurance** and **am not guaranteed insurance reimbursement. (I understand, I will be charged a $25 fee if I request additional copies of previously provided appointment receipts.)**

Cancellation, Rescheduling and, No-Show Policy A fee of $100 will be charged to the credit card on file if I cancel, reschedule or no-show with less than 24-hour's notice. I understand if no credit card number is on file, I will be required to pay the $100 fee before I can schedule any future appointments.

Late Arrival Policy I understand if I arrive ten (10) or more minutes past my scheduled appointment time, I may be asked to reschedule my appointment to another date and/or time.

Walk-In Appointment Policy I understand walk-in appointments are not available.

Medical Form(s) Requests I understand Willow Bend Sports & Spine Center may require up to seven (7) business days to complete medical form requests.

Medical Record Copies I understand a fee of $25.00 will be assessed for the first 25 pages (with an additional fee of $.75/page) to copy medical records and I will be required to provide a credit card for fees prior to implementing the copy request. There is NO FEE to fax or e-mail medical records to continuing care provider referrals.
NOTE: A "Medical Records Release" must be signed by the patient, or guardian, and submitted to our office prior to the processing of any records.

Patient Termination Policy I understand Willow Bend Sports & Spine Center reserves the right to terminate treatment at the doctor or staffs' discretion. Common reasons include but are not limited to 1. Use of foul language; 2. Chronic non-compliance of recommended treatment; 3. Abusive behavior toward doctor, staff, patients, or visitors. 4. Chronic late arrival or appointment no shows.

I have read and understand the office policies of Willow Bend Sports & Spine Center, the office of Dr. Jeff Eidsvig, D.C., P.L.L.C

_____ _____

Signature of Patient or Legal Guardian **Date**

Willow Bend Sports & Spine Center
Office Policies (Continued)

In accordance with Willow Bend Sports & Spine Center's "Cancellation, Rescheduling and, No Show Policy", **I understand a fee of $100 will be charged to the (non-HSA) credit card number below:**

PATIENT NAME_____

NAME ON CREDIT CARD_____

CREDIT CARD NUMBER_____

EXPIRATION DATE _____

CVV _____

ZIPCODE _____

_____ _____

Signature of Patient or Legal Guardian **Date**