Improving Lives & Performance

Dr. Jeff Eidsvig, D.C., TPI-CGFI
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New Patient Information / Change of Information

Date: ____

New Patient _____ **Change of Info** _____

Patient Name: _______________________________________**Age:** ______________________

Date of Birth: ______________________________**Gender (circle one):** **MALE** **FEMALE**

E-Mail: ____

Address: ______________________**City/State/Zip:** ___________________________________

Cell Ph#: ______________________________**Work Ph#:** _____________________________

Emergency Contact: ____________________________**Ph#:** ____________________________

Referred By: ___________________________**Internet (Search Engine):** __________________

Primary Care Physician: ____

Ph#: _____________________________

Patient Relationship Status (circle one): **MARRIED** **SINGLE** **DIVORCED** **WIDOWED**

Authorization To Release Information: I hereby authorize the above named agency to release any/all treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services of Dr. Jeff Eidsvig, D.C., PLLC and authorize payment directly to Dr. Jeff Eidsvig, D.C., PLLC for services rendered. I accept responsibility for payment of any charges not paid or accepted by my insurance carrier.

____ ___________________

Signature of Patient/or Legal Guardian **Date**

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Willow Bend Sports & Spine Center
Patient Intake Form

Name: ______________________________ **Date:** _________________________________

Date of Birth: _________________________ **Contact PH#:** _______________________

NOTE: Laser Therapy is NOT included in Office Visit and is an additional $25
In order to provide the most effective results, please limit each visit to one area of treatment

1. **What is the "main" reason for your visit?**____

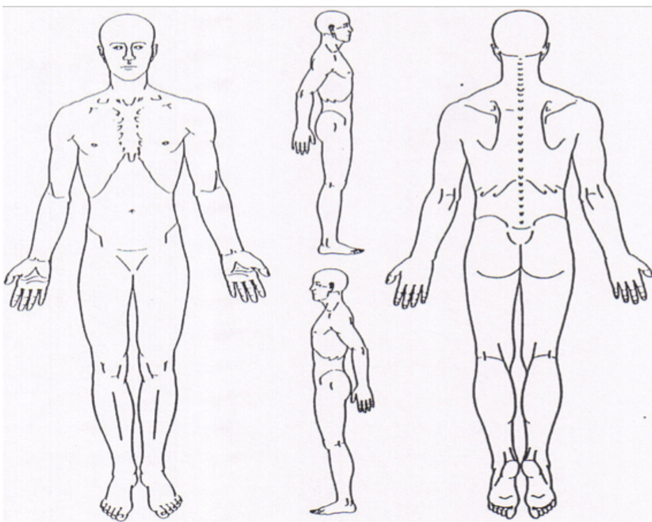
2. **On the scale below, please indicate the severity of your main complaint (circle one)**

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

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

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

4. **Use the diagram and symbols below to show where you are currently experiencing your main complaint today:**



A = Aching	**B = Burning**
C = Cramping	**D = Dull**
N = Numbness	**S = Sharpness**
P = Pins/Needles	**ST= Stabbing**
^^^ = Shooting	**/// = Throbbing**
+++ = Tingling	**T = Tightness**
O = Other:______________________________	

5. Please describe ALL details concerning your main complaint:

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Willow Bend Sports & Spine Center
Patient History

Patient Medications: (Please include Vitamins, Herbs, or Supplements)

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Past Medical Conditions/Hospitalizations/Surgeries

_________________________________ _________________________________
_________________________________ _________________________________

Patient Allergies: (Please list ALL food and medicine allergies)

_________________________________ _________________________________
_________________________________ _________________________________

Patient Family History: (Please list any medical conditions)

Father:____________________________**Mother:**____________________________
Brother(s):_________________________**Sister(s):**___________________________
Grandmother(s):__________________**Grandfather(s):**_______________________

Information Regarding Current Symptoms and Past Care: (Please circle)

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 as a result of your condition?	Yes	No
Have you had an MRI, X-Ray, CT Scan, or Bone Scan for your condition(s) within the past year?	Yes	No

Please indicate when and which Imaging Facility:

____

Social History

Patient Occupation (Describe Environment):

____

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 week.
Illegal Drugs:	Yes	No	If yes, what substance:

____

Patient Work History (circle one): Employed Unemployed Retired Homemaker Student
Patient Relationship Status (circle one): Single Married Divorced Widow

____ __________________________
Signature of Patient/or Legal Guardian **Date**

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Willow Bend Sports & Spine Center
Treatment for Consent / HIPPA Form

First Name: ________________________________ Last Name: ____

My preferred method of communication regarding my medical conditions is indicated below:
Ph#: _________________________________ Email: ____________________________________
If the above method is by phone, please check the appropriate box below (check one):
_____ Leave a message with detailed information _____ Leave a message with call back number only
Please note you are responsible for any charges incurred in receiving our communications.

____
Signature of Patient/Legal Guardian Date

Insurance Authorization: I hereby authorize the release of medical or other information to my insurance company (via fax or e-mail) concerning charges/treatments provided to me by the doctor(s) listed. I hereby assign benefits and understand payment is due at the time services are rendered including my deductible, co-payment, co-insurance, or any other balances not paid by my insurance carrier (excluding contractual allowances) at the time of service. If, after 60 days, insurance payment has not been received, I understand all charges are my responsibility and payable immediately. Additionally, I understand I am responsible for providing the referral from my primary care physician. In the even such a referral has not been provided to the doctor(s) at Willow Bend Sports & Spine Center, I agree to pay for the service(s) at the time they are rendered.

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 evaluation and health care for the above-mentioned patient.

Patient Privacy Practices: I understand my rights regarding my protected health information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). 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, which contain a complete description of the uses and disclosures of my protected health information. I understand the Notice of Privacy Information serve 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 actually 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, payment, and operations, including those activities performed in order to improve the quality of care. I acknowledge receipt of this information and give authorization for the release of my "Medical Records/Privacy Information" to the following:

Disclosure to Friends and/or Family Members: I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name: ____ Relationship To Patient ______________________

Name: ____ Relationship To Patient ______________________

____ ______________________
Signature of Patient/or Legal Guardian Date

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Willow Bend Sports & Spine Center
Office Policies

First Name: ____________________________ Last Name: _______________________________________

<u>10 Minute Late Policy</u>: Patients arriving to our office over ten (10) minutes past their schedule appointment time will be asked to reschedule to another time and/or date.

<u>No Show Policy</u>: Patients scheduled for appointments who fail to show up will be documented as a "No Show" and will be assessed and responsible for payment of "No Show Fee": $100 for New Patients and $50 for Existing Patients.

<u>Walk In Appointments</u>: Willow Bend Sports & Spine Center is an appointment only office and walk in appointments are not available.

<u>Payment</u>: All payments are due at time of service. Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled and required to submit payment prior to another appointment another can be scheduled. Accepted methods of payment include cash, check, credit, and debit cards. Patients are responsible for their account balances, and expected to pay within 90 days or their balance will be sent to a collection agency. Per insurance company policies, benefits quoted to our staff via your insurance provider are "not guaranteed" until submitted and processed by your insurance provider.

<u>Patient Termination Policy</u>: A patient may be terminated from the office at the discretion of the patient's doctor/staff. Common reasons include, but are not limited to: use of foul language, chronic non-compliance with recommended treatment, and abusive behavior to staff, doctors, visitors, or other patients.

<u>Medical Form or Medical Request Form Completion</u>: Please be aware our staff requires 5-7 business days to complete all medical forms or requests.

<u>Copying of Medical Records</u>: Patients requesting copies of their medical records will be assessed a $25.00 fee for the first 25 pages with an additional fee of $0.75/page. No fee will be assessed, when an abstract or referral is sent to a continuing care provider. A "Medical Records Release" of information must be signed and submitted to our office by the patient/or guardian of patient prior processing all requests.

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

____ ________________________

Signature of Patient/or Legal Guardian **Date**

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