Pittsburgh Physical Medicine

Chiropractic-Physical Therapy-Massage Therapy

Case History/Patient Information

Required information marked with (*)

*Name: ______________________________________ Social Security #_______________________

*Address: ________________________*City: _________________*State: _______*Zip: __________

*E-mail address: _____________________________*Contact Phone Number: ___________________

Age: _________ Birth Date: _____/_____/__________ Marital: M S W D

*Occupation: _____________________________ Employer: ________________________________

How many children? _______

*__How were you referred to our office? Patient Referral: ☐ Doctor Referral: ☐ Promotion: ☐ Website: ☐ Social Media: ☐ Event: ☐ Other: ☐*Where/When/Who:__

____

*Family Medical Doctor: *First name: ___________________ *Last Name: ______________________

*Practice Name and Location: ____

*When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?: (Please Circle) Yes No

*Emergency Contact: _______________ *Address: _____________________ *Phone: ___________

Please circle any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Medical Savings Account & Flex Plans

*Name of Primary Insurance Company:____

Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, 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 to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

*Patient's Signature: ____ Date: ________________

Guardian's Signature Authorizing Care: ____________________________ Date: ________________

History of Present and Past Illness:

Chief Complaint: Purpose of this appointment: ____

Date symptoms appeared or accident happened: ____

Is this due to: Auto___ Work____ Other____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: ______________

____

Do you have a history of stroke or hypertension? ____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

Do you have any allergies of any kind? Yes No

If yes, describe: ____

Do you have any congenital conditions? ___Yes ___ No If YES, Describe ______________________________

Women: Are you pregnant? ___________________

INFORMED CONSENT

PATIENT NAME ____

Clinic Name: __Pittsburgh Physical Medicine and Chiropractic

Doctor's Name: __Justin Foltz DC

Address: 5916 Penn Avenue Pittsburgh PA, 15206

Phone:__412-404-8337____ Fax: _412-404-8496

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ______________________ Printed Name ___________________________________

Signature ____________________________________

Signature of Parent or Guardian (if a minor) ______________________

HIPAA ACKNOWLEDGEMENT

Patient's Name: _______________________________

I acknowledge that I have been advised of the Notice of Privacy Practices for Protected Health Information by Pittsburgh Physical Medicine and Chiropractic. I acknowledge that this notice is posted in the clinic* and that I may request a copy of this notice at any time.

***HIPAA rights posted on bulletin board**

______________________________________ ______________

Patient Signature Today's Date

______________________________________ ______________

Staff Signature Today's Date