Date___/___/___

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION

FULL NAME_____ DATE OF BIRTH___/___/___ AGE___ GENDER: MALE ☐ FEMALE ☐

ADDRESS_____ APT #_____ CITY_____ STATE_____

ZIP CODE_____ PHONE (_____) _____-_____ SOCIAL SECURITY NUMBER _____-_____-_____

CELL PHONE (_____) _____-_____ EMAIL _____@_____.com

EMPLOYER'S NAME_____ OCCUPATION_____

WORK ADDRESS_____ CITY _____ STATE_____ ZIP CODE _____

WORK PHONE (____)____-_____ EXT____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOW ☐ PARTNERED ☐

EMERGENCY CONTACT_____ RELATION: _____ PHONE NUMBER (_____)_____

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICAN _____ PHONE NUMBER (____) _____-_____

OTHER DOCTOR_____ PHONE NUMBER (____) _____-_____

HOW DID YOU FIND VELOCITY?

FRIEND: _____

FAMILY: _____ DRIVE BY: YES ☐

WEBSITE: YES ☐ PARTICULAR SERVICE (ex. ART, Dry Needling): Which One: _____

INSURANCE INFORMATION

RELATIONSHIP TO INSURED: SELF CHILD SPOUSE SPOUSE'S NAME_____

INSURED'S EMPLOYER: SAME AS ABOVE OTHER_____

INSURED'S SSN AND DOB: SAME AS ABOVE OTHER: SSN:_____-_____-_____ DOB:_____-_____-_____

PRIMARY INSURANCE CO _____ ADDRESSS_____

CITY_____ STATE_____ ZIP CODE_____ PHONE NUMBER (_____) _____-_____

POLICY NUMBER _____

SECONDARY INSURANCE CO_____ ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ PHONE NUMBER (_____) _____-_____

AUTHORIZATIONS

1. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
2. I authorize payment of any medical benefit from third parties for benefits submitted from my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I know or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products or services rendered.
3. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT'S SIGNATURE_____ DATE_____

GUARDIAN'S SIGNATURE_____ DATE_____

VELOCITY SPORTS MEDICINE

Sports Chiropractic * Injury Rehabilitation * Dry Needling * Manual Therapy * Nutrition

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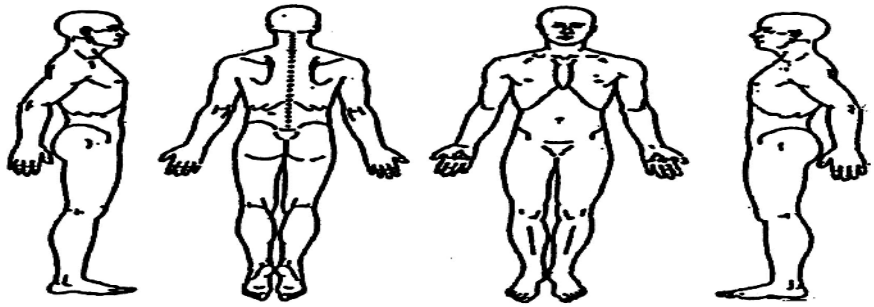
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem related to a: □ Auto Accident □ Workman's Compensation □ Personal Injury Case □ N/A

2. Indicate on the drawings below where you have pain/symptoms (please circle)



3. How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ Other:_____

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle one*)

6. How often do you experience your symptoms?

Never 1-10% *of the time* 11-20% 21-30% 31-40% 41-50% 51-60% 61-70% 71-80% 81-90% 91-100% Constantly

7. Who else have you seen for your problem?

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	□ No one

8. How long have you had this problem?_____

9. How do you think your problem began?

_____

10. What aggravates your problem?

_____

11. What alleviates your problem?

_____

12. What are your goals of treatment (besides reduced pain)?

_____

13. What activities, sports, or hobbies are impacted by this condition that you want to get back to?

_____

14. When getting muscle/soft tissue therapy done, how much pressure do you typically like?

0 1 2 3 4	**5 6 7 8 9**	**10 (*Please circle*)**
Don't Like Muscle work	Medium Pressure	Deep Tissue

TURN OVER

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Occupation _____

15. What is your: Height_____ **Weight** _____

16. How would you rate your overall nutritional health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following, and who they are:
□ Rheumatoid Arthritis_____ □ Diabetes_____ □ Lupus _____
□ Heart Problems_____ □ Cancer_____ □ ALS _____

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Constitutional

Past	Present	
□	□	Cancer/Tumor
□	□	Abnormal Weight Gain/Loss
□	□	Loss of Appetite
□	□	Abdominal Pain
□	□	General Fatigue
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Fever/Chills
□	□	Bladder Infection
□	□	Hepatitis

Neurological

□	□	Muscular Incoordination
□	□	Visual Disturbances
□	□	Dizziness
□	□	Loss of Bladder Control
□	□	Trouble Speaking
□	□	Trouble Swallowing
□	□	New Type of Headache
□	□	Fainting/Drop Attacks
□	□	Seizures
□	□	Hearing Loss/Change

Musculoskeletal

Past	Present	
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Ehlers Danlos
□	□	Joint Replacement
□	□	Ankylosing Spondylitis
□	□	Osteoporosis/Osteopenia

Respiratory

□	□	Asthma
□	□	Chronic Sinusitis
□	□	Emphysema
□	□	Shortness of Breath

Cardiovascular

□	□	High Blood Pressure
□	□	Heart Attack
□	□	Chest Pains
□	□	Stroke
□	□	Swelling
□	□	Pacemaker

Other

Past	Present	
□	□	Kidney Disorders
□	□	Diabetes
□	□	Tobacco Use
□	□	Marijuana Use
□	□	Drug/Alcohol Dependence
□	□	Allergies
□	□	Depression
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS
□	□	Use of Needles
□	□	Hormonal Replacement

For Females Only

□	□	Birth Control Pills
□	□	Pregnancy

When?_____

Last menstrual cycle_____
Post-menopausal □ Yes □ No

□ □ **Other Symptoms or Conditions:**_____

20. List all prescription medications you are currently taking:
_____

21. List all of the supplements you are currently taking:
_____

22. List all surgical procedures (include what year):
_____

23. What activities do you do outside of work?
_____

24. Have you had any MRI's or Imaging showing any issues? □ No □ Yes
if yes, why _____

25. Have you ever seen a Chiropractor before? □ No □ Yes
if yes, when and for what_____

26. Have you had significant past trauma? □ No □ Yes explain: _____

27. Anything else pertinent to your visit today? _____

Patient Signature_____ **Date:** _____

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Office Policy and Insurance

This agreement is between VELOCITY SPORTS MEDICINE and you the patient whereas I do hereby authorize and agree to pay for services rendered to me by DR. MATTHEW MEYERS and/or staff during my course of treatment as agreed upon. I also hereby authorize and agree to pay in full any outstanding balance due on my account if requested at the time of my release from care. I instruct an insurance carrier that may be liable to pay my physician directly for any outstanding medical bills.

I understand that if I have a personal injury protection policy (PIP) that it is the contractual obligation of my insurer to pay any and all medical bills, which are the result of an automobile accident, unless my benefits have been exhausted. I instruct any insurance company that may be liable to pay to pay my doctor within 30 days of the date of receipt of my claims, as required by the Connecticut Department of Insurance, by way of issuance of a separate draft make payable to VELOCITY SPORTS MEDICINE.

In the event I so choose to have any attorney represent me in this case, I do hereby instruct said attorney to pay in full any outstanding monies due my physician at the time of settlement with any liability claim that may result from this case. My attorney shall not withhold any portion of the amount due to my physician under this agreement to offset attorney's fees. I also instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to VELOCITY SPORTS MEDICINE. I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by any insurance companies. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment.

I understand that VELOCITY SPORTS MEDICINE has the right to expect good faith payments on my account and that full payment is being deferred only until such time as any insurance company makes payment on my account. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

I understand that VELOCITY SPORTS MEDICINE does not render any services on the assumption that their charges will be paid by any insurance company. Patients who carry health insurance should remember that professional services are rendered and charged to the patient if not paid in full by the insurance company. This excludes patients with an accepted workers' compensation injury. Insured patients are expected to take care of their fees and/or patient portion as services are rendered. Even though an insurance claim is filed, you will receive a statement if your account has a balance due.

Methods of payment

(Accepted workers' compensation patients are excluded)

A. Payment at the time of service is expected unless prior arrangements are made in advance. Cash, checks and credit cards are accepted.

B. If participating in the Well Care Program, which allows the patient to pay in advance for the recommended adjustments, and thereby receive subsequent savings, or other cash payment agreement, the patient's insurance company will not be billed. However, if the patient suffers an injury or illness, which merits injury/illness care, the patient's insurance may be utilized.

_____ _____

Patient/Patient's Parent or Guardian Signature Date

Acknowledgement and Agreement of Receipt

As the insurance adjuster or attorney on this claim, I acknowledge that I have received notice of the patient's agreement above and will abide as agreed upon and instructed from_____ (patient's name).

_____ _____

Attorney or Adjuster Signature Date

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to VELOCITY SPORTS MEDICINE

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at VELOCITY SPORTS MEDICINE. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient/Patient's Parent or Guardian Signature Date

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for VELOCITY SPORTS MEDICINE regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Dr. Matthew Meyers, Clinic Privacy Officer, 203-557-6965, 221 Post Road West Westport, CT 06880.

My signature herein below constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for VELOCITY SPORTS MEDICINE.

My signature approves all above consent forms.

_____ _____

Patient Signature/parent or guardian Date

_____ _____

Patient's legal representative (if required) Date

I signed by a patient's legal representative, please state representative's relationship to patient

_____

Appointment Cancellation Policy

If you need to cancel your appointment, please give us 24 hour notice. We do charge 50% of the total cost of the visit for no shows or appointments that were not cancelled within the 24 hour time line. Please note a copayment is not equivalent to the cancellation fee. Three no shows in the same calendar year will result in payment of the full price of the visit going forward. Thank you for your understanding.

Patient Signature: _____