COLUMBUS PHYSICAL MEDICINE CENTER

Date: _____

Patient Information

Name: _____
Last First MI

Email:

_____

Physical Address:_____City:_____State/zip_____

Mailing Address:_____City:_____State/zip_____

Phone # (Home)_____(Work)_____(Other)_____

Date of Birth:_____/_____/_____Sex:☐Male ☐Female SS#: _____

Marital Status:☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Employer_____Employer Phone:_____

How did you hear about our practice? _____

Emergency contact: Name:_____Relation:_____Phone #: _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐Auto ☐ Work ☐ Other _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self):_____Phone # _____

Do you have health insurance? ☐Yes ☐No Name of Carrier: _____

Do you have secondary insurance? ☐Yes ☐No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with_____and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, COLUMBUS PHYSICAL MEDICENE CENTER. INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X)_____**DATE** _____

COLUMBUS PHYSICAL MEDICINE CENTER

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fainting
- ❑ Sleeping Difficulties
- ❑ Fever
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Chest Pain
- ❑ Cold Feet
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Bowel/Bladder Changes
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Blood Clots
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Congenital Heart Dz
- ❑ Sickle Cell Disease
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ COPD
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Tay-Sachs
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Irregular Heart Beat
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Hemophilia or blood disorder
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Other _____
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Sleep Apnea
- ❑ GERD
- ❑ Fibromyalgia
- ❑ Myocardial Infarct
- ❑ Heart Failure
- ❑ Peripheral Vasc. Dz
- ❑ Heart Valve Disorder
- ❑ Muscular Dystrophy
- ❑ Lupus
- ❑ Restless Legs

Surgical History

Please list any surgeries and/or hospitalizations you have had:

Surgery Type	Date of Surgery
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____

Family History

Is there a family history of any of the following conditions? Indicate family member including parents, grandparents, and siblings.

- ❑ Heart Disease _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Arthritis _____
- ❑ Other _____

COLUMBUS PHYSICAL MEDICINE CENTER

Social History

Do you drink alcohol ☐ Yes ☐ No
If yes, how many drinks_____a day_____drinks/week
- ❑ Beer
- ❑ Wine
- ❑ Liquor

Do you smoke / dip ☐ Yes ☐ No If yes; how many packs / pouches per day_____per week_____
How long have you smoked / dipped _____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

Medications

Please initial:

_____ I authorize Columbus Physical Medicine Center, Inc. to obtain my medications electronically from my pharmacy

Pharmacy & Location: _____

Allergies

Please check any allergies you may have (Allergy & Reaction)

❑ ACE Inhibitors	❑ Antihistamines	❑ Antipsychotic Drugs	❑ General Anesthesia	❑ Macrolides
❑ Egg/Poultry	❑ Environmental	❑ Fish Products	❑ Latex	❑ Penicillin
❑ Gluten Protein	❑ Influenza Vaccine	❑ Lactose	❑ Peanuts	❑ Shellfish
❑ Milk Products	❑ Niacin	❑ NSAIDS	❑ Salicylates	
❑ Pollen	❑ Quinolones	❑ Ragweed	❑ Tetracyclines	
❑ St Johns Wort	❑ Sulfa	❑ Supartz	❑ Cephalosporin	
❑ Tricyclic Compounds	❑ Vitamin C	❑ Bee Sting	❑ Glutathione	

❑ Other_____

Have you had your Influenza Vaccine this year?
❑ Yes ❑ No If yes, Where & When? _____

Have you had your Pneumococcal Vaccine this year?
❑ Yes ❑ No If yes, Where & When? _____

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X)_____**DATE** _____

COLUMBUS PHYSICAL MEDICINE CENTER

CONSENT TO CARE

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor provides him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare services, if known or to learn through health care procedures or diagnostics, that the symptoms from whatever he/she is suffering from are related to latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

I have read, understand, and agree to the above, mentioned statements.

Patient's Signature:_____ **Date:**_____

COLUMBUS PHYSICAL MEDICINE CENTER

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____
_____
_____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

COLUMBUS PHYSICAL MEDICINE CENTER

MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. **There is a $25.00 charge for NO CALL/NO SHOW appointments.**

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

COLUMBUS PHYSICAL MEDICINE CENTER

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
11. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
12. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
13. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
14. This office accepts MasterCard, Visa, American Express, Discover Card, Personal Checks, Money Order and Cash.
15. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
16. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____

Patient Signature or Responsible Party Date

COLUMBUS PHYSICAL MEDICINE CENTER

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ **DOB:** _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Columbus Physical Medicine Ctr. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is:_____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Columbus Physical Medicine Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date

COLUMBUS PHYSICAL MEDICINE CENTER

Authorization To Release Medical Records

Patient Information:

Name (please print): _____ DOB: _____

Information To Be Released From:

Facility or Provider: _____

Address: _____

Phone/Fax: _____

Information To Be Released To:

Columbus Physical Medicine Center
118 Enterprise Court, Suite B, Columbus, GA 31904
Phone: (706)330-1389 Fax: (706)330-1392

Information To Be Released:

_____The most recent 2 years of pertinent information. (Chart notes, labs, x-rays, and special tests)
_____All medical records
_____Specific Information:_____

Purpose for which the disclosure is being made: (please circle one)

Attorney Insurance Doctor Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial)

_____Drug/Alcohol abuse/treatment & Diagnosis
_____HIV/AIDS diagnosis/treatment/testing
_____Sexually Transmitted disease
_____Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person/organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature _____ Date_____
(Patient, guardian, or Authorized representative)

This authorization will expire 120 days from the date signed.
Possible copying fee required