ALTAIR
INTEGRATIVE WELLNESS
YOUR HOME FOR REGENERATIVE MEDICINE

New Patient Information

Patient Information

Full Name:_____ **Date Of Birth**:_____

Phone Number:_____ **Email**:_____

Street Address:_____ **State**:_____

Apt#_____ **City**:_____ **Zip**:_____

Emergency Contact Information

Full Name:_____ **Phone Number**:_____

Email:_____

Street Address:_____ **State**:_____

Apt#_____ **City**:_____ **Zip**:_____

Social History

Gender: ○ Male ○ Female ○ Other:_____

Race: ○ African American ○ White ○ Asian ○ American Indian or Alaskan Native ○Decline to specify

○ Native Hawaiian or other Pacific Islander ○ Other:_____

Smoking use: ○ Yes ○ No ○ Occasional **Marijuana Use**: ○ Yes ○ No ○ Occasional

Alcohol Use: ○ Yes ○ No ○ Occasional **Caffeinated Beverage Use**: ○ Yes ○ No ○ Occasional

Health History

Medications:

Allergies:

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Health History Cont.

Do you have any of the following health conditions? Please check all that apply.

- ○ No Problems
- ○ AIDS
- ○ Measles
- ○ Alcoholism
- ○ Multiple Sclerosis
- ○ Allergies
- ○ Mumps
- ○ Arthritis
- ○ Neck or Back Problems
- ○ Asthma
- ○ Polio
- ○ Cancer
- ○ Rheumatic Fever
- ○ Diabetes
- ○ Sexually Transmitted Diseases
- ○ Foot or Ankle Problems
- ○ Shoulder, Elbow, or Wrist Problems
- ○ Gout
- ○ Thyroid Issues
- ○ Heart Disease
- ○ Tuberculosis
- ○ Blood Pressure - High or Low
- ○ Typhoid Fever
- ○ Hip Disorders
- ○ Ulcer
- ○ Knee Injuries

Have you had any of the following injuries? Please check all that apply**.**

- ○ No Injuries
- ○ Fractured or Broken Bone
- ○ Body Piercing
- ○ Injured in an Accident
- ○ Neck or Back Bracing
- ○ Received a Tattoo
- ○ Spinal or Nervous Disorder
- ○ Other:_____

Have you had any of the following surgeries? Please check all that apply**.**

- ○ No past surgeries
- ○ Appendectomy
- ○ Bypass Surgery
- ○ Cosmetic Surgery
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spinal Surgery
- ○ Tonsillectomy
- ○ Other:_____

Family Medical History: Please select those that apply.

•Arthritis
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

•Cancer
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

•Diabetes
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

•Hypertension
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

•Stroke
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

•Thyroid Issues
- ○ No Family History
- ○ Parent
- ○ Sibling
- ○ Both Parent & Sibling

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Reason For Visit

Areas of discomfort/pain:_____

Onset of discomfort/pain:_____

Rate Your pain on a scale of 1-10 (With 1 being the lowest and 10 being the highest):_____

Frequency of pain: ○ Constant ○ At Rest ○ Off/On ○ With Activity ○ Other:_____

What time of day is the pain at its worst: ○ Morning ○ Night ○ Afternoon ○ During sleep ○ All Day

Is there anything you do that increases or decreases the pain:_____

Quality of pain: ○ Aching ○ Stabbing ○ Deep ○ Sharp ○ Throbbing ○ Burning ○ Dull ○ Other:_____

What symptoms are you experiencing if any? (Choose those that apply)**:**

○ Headaches
○ Migraines
○ Pain in neck
○ Pain when moving head
○ Neck feels out of place
○ Pain when lifting
○ Deep shoulder joint pain
○ Fingers go to sleep
○ Hands or feet cold
○ Loss of grip strength
○ Feet/Legs go to sleep
○ Sensation of pins and needles
○ Pain with breathing
○ Pain when bending over
○ Pain when leaning side to side
○ Leg cramps
○ Numbness in foot/toes
○ Upper back pain
○ Mid back pain
○ Lower back pain
○ Wrist pain
○ Unstableness/Vertigo

Has your discomfort/pain affected any of the following activities?

○ Ability to do yard work
○ Quality of life
○ Dressing yourself
○ Ability to drive a car
○ Ability to care for your family
○ Getting to sleep
○ Getting in and out of a car
○ Grocery Shopping
○ Household chores
○ Grooming yourself
○ Raising out of a chair
○ Sexual activities
○ Showering or Bathing
○ Ability to play sports
○ Concentrating
○ Lifting objects
○ Using a computer
○ Typing or writing
○ Ability to go to work
○ Bending over
○ Climbing stairs
○ Exercising
○ Bending to one side
○ Reaching overhead
○ Sitting
○ Standing
○ Walking

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Consent to Treat

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures may also be used.

The nature of physical therapy treatment: It is provided by physical therapists who promote, maintain, or restore health through physical examination, diagnosis, management, prognosis, patient education, physical intervention, and/or rehabilitation. The patient may be asked to do physical activities both in the clinic and outside the clinic.

The nature of massage therapy treatment: Massage therapists manipulate the soft tissues of your body - muscle, connective tissue, tendons, ligaments, and skin. Using varying degrees of pressure and movement. Patients level of comfortability is always considered especially regarding undressing. Unclothed patients will remain draped throughout the massage. Massage is generally considered part of integrative medicine.

Possible Risks: As with any health care procedure, complications are possible following any of the therapies we offer. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck upon a rotational neck adjustment. In our office, our doctors do not practice the rotational neck technique. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Post massage therapy the patient may experience muscle soreness, skin irritation, or other minor complications such as superficial bruising.

*It is imperative that the patient listens to the provider for post treatment care.

Probability of risks occurring: I do not have any injuries or conditions that prevent me from receiving chiropractic, physical therapy, or massage therapy. I understand the importance of informing my doctor or therapist of all medical conditions and medications that I am taking or have, and that there may be additional risks based on my physical condition. I understand that risks of complications due to treatment are "rare" and that there are contraindications for all therapies and treatments.

I have read the explanation above of chiropractic treatment, physical therapy, and massage therapy.

I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment.

I agree that I have answered all the above questions as truthful as possible. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I agree that this consent to treatment is for this and any following treatments for chiropractic, physical therapy, and massage therapy.

Patient Signature:_____ **Date:**_____

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FINANCIAL POLICY

Insurance Co-Pays
In accordance with my insurance contract, I understand that co-payments are due at the time of service. If I have co-Insurance I understand that co-insurance amounts may be collected at the time of service, and at the time of interventional procedures are scheduled.

Private Pay
If I have no insurance coverage, or insurance with which the clinic and treatment center does not participate, or the clinic and treatment center is unable to verify current coverage, I understand full payment is expected at the time of service and at the time interventional procedures are scheduled. A full fee schedule will be provided upon request.

Refund Policy
I understand that the amounts collected from me are based on information received by the clinic and treatment center from my insurance carrier. Refunds are made only after a written request is submitted and there has been full insurance reimbursement for all medical services on the account, regardless of the date of service. Please allow 4-6 weeks for the request to be processed.

Verification of Benefits
Insurance policies are individualized per patient plan. The clinic and treatment center may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Collections
I understand that once an account is placed in collections status, all future services must be paid in full at the time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

No Show or Late Cancellations/Returned Checks
Cancellations made less than 24 hours in advance or any "No Show" appointments are subject to a $25 charge for office visits. If a payment is made on an account by check, and the check is returned for any reason patient will be responsible for the original check amount and an additional $25.00 service charge These charges are my responsibility and will not be billed to my insurance carrier.

Responsibility for Valuables
I understand and acknowledges that provider is not responsible for the loss or damage to, or theft of any of my or dependents' personal possessions, including, but not limited to money, jewelry, clothing or valuables, while on premises. PATIENT's signature verifies that PATIENT authorizes assignment of benefits, has read the disclosure statement, understands PATIENT responsibilities, and agrees to the terms and conditions described therein.

FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT
This agreement is made and entered into on this date between Altair Integrative Wellness, Inc. the provider of medical services, hereinafter referred to as PROVIDER and you the patient receiving medical services, hereinafter referred to as PATIENT. All Charges for medical services rendered by PROVIDER are due and payable by PATIENT at the time of service.

Patient Signature:_____ **Date:**_____

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature:_____ **Date:**_____