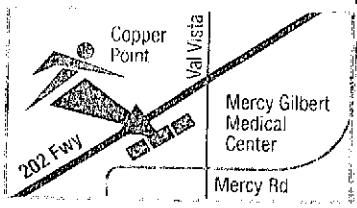


OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

PATIENT APPLICATION FOR TREATMENT

Date: _____

Name: _____ Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Social Security # _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

# of Children: _____ What are their ages? _____ Email: _____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

May We Contact Your PCP, if needed? ☐ Yes ☐ No

Primary Care Physician: _____ Phone: (_____) _____-_____

PCP's Office Name: _____ City: _____ State: _____ Zip: _____

Have you ever had Chiropractic Care? ☐ Yes ☐ No If Yes, how long ago? _____

Have you ever had Physical Therapy? ☐ Yes ☐ No If Yes, how long ago? _____

Chief complaint or reason for the office visit? _____

Is your visit related to an Auto Accident? ☐ Yes ☐ No Is your visit related to a Work Related Accident? ☐ Yes ☐ No

Have you had a Job Disability in the last 12 months? ☐ Yes ☐ No Do you have Health Insurance? ☐ Yes ☐ No

Who referred you to the office? _____

Do you exercise? ☐ Yes ☐ No If Yes, how often? _____ Type? _____

Have you ever had surgery? ☐ Yes ☐ No If Yes, what surgery and when?

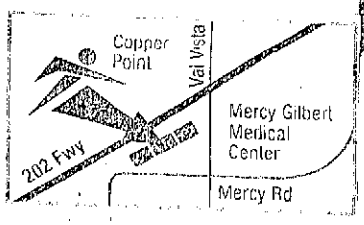
1. Surgery_____ Date _____/____/_____
2. Surgery_____ Date_____/____/_____
3. Surgery_____ Date_____/____/_____

Pleas List ALL Medications you are currently taking. If you need more room please inform the front desk.

NAME OF MEDICATION/VITAMIN	DOSAGE	FREQUENCY	WHO PRESCRIBED	PURPOSE FOR TAKING

OSPI is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Your signature below acknowledges that you have been provided with and given an opportunity to read the Notice of Privacy Practices. You are also agreeing to payment and health care operations as described in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

PATIENT HISTORY

1. **Chief Complaint:** _____ **1a. Onset**_____/_____/_____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

2. **Chief Complaint:** _____ **2a. Onset**_____/_____/_____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

3. **Chief Complaint:** _____ **3a. Onset**_____/_____/_____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Has the pain ever been a level 9 or 10? ☐ Yes ☐ No (Circle which complaint) 1 2 3

Aggravating (feels worse)

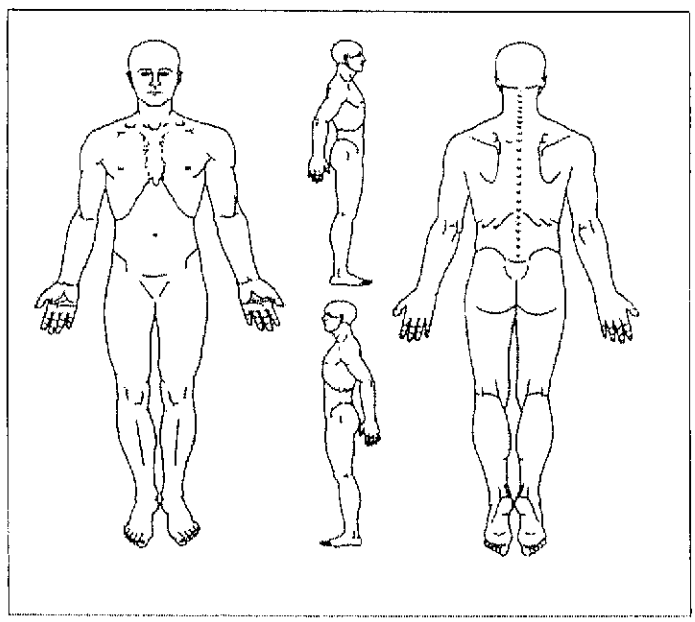
Sitting	1 2 3	Looking up	1 2 3
Stooping	1 2 3	Look down	1 2 3
Coughing	1 2 3	Movement	1 2 3
Standing	1 2 3	Rest	1 2 3
Lifting	1 2 3	Stooping	1 2 3
Straining	1 2 3	Typing	1 2 3
Walking	1 2 3	Driving	1 2 3
Sleeping	1 2 3	Laying supine	1 2 3
Reaching	1 2 3	Chores	1 2 3
Bending	1 2 3	Exercise	1 2 3
Sneezing	1 2 3	Stairs	1 2 3
Twisting	1 2 3		

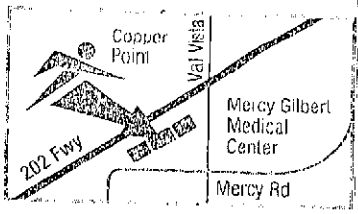
Relieving (feels better)

Sitting	1 2 3	Ibuprofen	1 2 3
Standing	1 2 3	Medication	1 2 3
Laying down	1 2 3	Adjustments	1 2 3
Knees bent up	1 2 3	Stretching	1 2 3
Heat	1 2 3	Exercise	1 2 3
Movement	1 2 3	Rest	1 2 3
No movement	1 2 3		
Use supports	1 2 3		
Ice	1 2 3		
Pain get	1 2 3		

Please show <u>where</u> on the body below you are experiencing <u>all</u> of your current complaints by placing the letter(s) on the left on that specific area.

A: Ache
B: Burning
C: Cramping
D: Dull Pain
S: Stabbing
N: Numbness
R: Radiating
T: Tingling
X: Sharp Pain
Z: Deep Pain
PP: Pin Prick
TH: Throbbing





OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

PATIENT HISTORY – cont'd

Have you ever had the condition(s) in the past? ☐ Yes ☐ No If Yes, please indicate what sort of treatment you have ever had:

☐ Hospitalization ☐ Chiropractic care ☐ Physical Therapy ☐ Medical doctor ☐Other _____ ☐ None

Have you ever lost work due to your condition(s)? ☐ Yes ☐ No If Yes, dates? _____

Are you pregnant? ☐ Yes ☐ No What was the first day of your last menstrual cycle? _____

Circle ALL past/present conditions that apply to you.

Abdominal bleeding	Convulsion	Heart murmur	Pleurisy
Allergies	Cough	Hepatitis	Pneumonia
Anemia	Depression	Hoarseness	Pus in urine
Arthritis	Diabetes	High blood pressure	Rheumatic fever
Asthma	Diarrhea	Indigestion	Shortness of breath
Emphysema	Difficulty swallowing	Irregular heart beat	Stroke
Back pain	Dizziness	Kidney infection	Swelling of feet
Spinal disorders	Depression	Kidney stone	Swollen or painful joints
Black tarry stool	Double vision	Leg pain	T.B.
Bleeding stool	Enlarged heart	Lung disease	Thyroid disease
Blood in urine	Epilepsy	Lyme disease	Ulcer
Bleeding disease	Fainting spells	Nocturia	Venereal disorders
Cancer	Gallstones	Nosebleeds	Vomited blood
Change in bowel habits	Gall bladder disorder	Nervous disorder	Other
Chest pain	Glaucoma	Painful urination	
Colitis	Headaches	Paralysis	
Constipation	Heart disease	Phlebitis	

This next column, be it your last to fill in thank goodness, is vitally important to us. It lets us know the level of desire you have in truly addressing the health concerns that you have indicated above. We pledge to fully investigate your conditions to our fullest ability and with that information, develop the most efficient means of treatment possible. So, in the event we believe it is within our scope and ability to help you once we fully understand your condition, please indicate to us what your level of commitment would be to correcting your condition(s)?

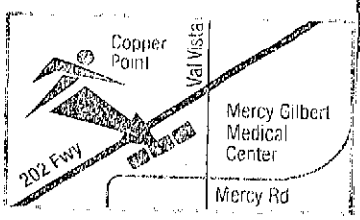
1	2	3	4	5	6	7	8	9	10

Low Medium High

Patient Name (please print): _____

Patient Signature: _____ Date _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

WELCOME TO OUR OFFICE

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Our office adheres to a strict "payment is due when services are rendered" policy.

Limited Release of Medical Information: I authorize Orthopedic Sports Performance Institute I to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.

Insurance Patients: I understand that my health insurance is a contract between myself, the insurance carrier and the provider. I understand that I am ultimately responsible for any fees for services rendered to me that does not get covered by my insurance company. I agree to pay my portion of fees at the time of treatment is rendered by OSPI I understand that this office accepts billing for Individual or Group policies, Personal Injury Claims, authorized Worker's Compensation, and Medicare.

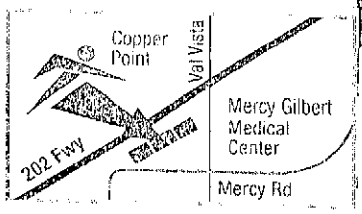
Authorized to Process Drafts: I agree that OSPI shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

Assignment of Cause of Action: In the event that any insurance company or third party obligated to make payment to me or to OSPI for the charges made for services rendered refuses to make such payment upon demand, I hereby assign, transfer, and convey to OSPI any and all cause of action that might exist in my favor against any such company or person. I authorize OSPI to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Collection/Attorney Fees: I agree to pay all costs of a collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services rendered. I agree to pay reasonable attorney fees or other such costs as a court might deem proper.

Discounts and Promotions: I agree that any discounts or promotions given to me applies if I agree to follow the full and complete treatment plan set forth by the doctor(s) of OSPI regardless if they are currently or formerly employed. In the event that I do not follow the treatment plan recommendations and I unilaterally remove myself from care, I agree and understand that any discount or promotion I have received will become null and void and I will be responsible for the complete balance in full less any payment made by me at the time of my unilateral discharge.

(Continued on next page)



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

WELCOME TO OUR OFFICE (continued)

I hereby request and consent to the performance of the indicated procedures (or on the patient named below, for whom I am legally responsible) by the Doctors of Chiropractic and/or the Licensed Physical Therapist and staff members who now or in the future work at OSPI at the address listed above. I have had an opportunity to discuss with the providers of care practicing in this clinic and/or with other office or clinic personnel the nature and purpose of the procedures indicated. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I am agreeing to the treatment recommendations that the doctor had laid out for me with the exception of the procedures I have declined to undergo. By declining any of the procedure recommendations, I understand that the doctor may be working from limited information and that I understand and take full responsibility for the fact that this may affect the overall outcome of my care and possibly not reveal any potential abnormal findings that would be viewed or exposed with the use of further diagnostic investigation.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office.

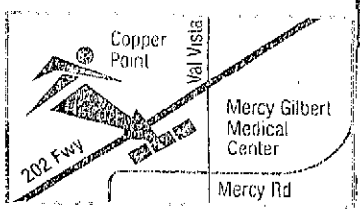
By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Name (please print): _____

Patient (or Legal Guardian's) Signature: _____ Date _____

Witness Name (please print): _____ Title: _____

Witness Signature: _____ Date: _____



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue claim reimbursement(s) directly to 'Orthopedic Sports Performance Institute for medical services rendered to myself and/or my dependents, regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Orthopedic Sports Performance Institute to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims, if necessary, for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Orthopedic Sports Performance Institute on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately.

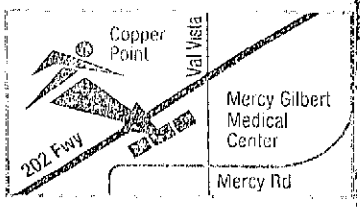
By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Name (please print): _____

Patient (or Legal Guardian's) Signature: _____ Date _____

Witness Name (please print): _____ Title: _____

Witness Signature: _____ Date: _____



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

INSURANCE SUBSCRIBER ACKNOWLEDGEMENT FORM

Orthopedic Sports Performance Institute continues to provide as many options for in-network insurance coverage as possible. Unfortunately, it is not feasible to be in-network with all insurance providers. This does not affect your care. As a courtesy, we submit all claims to your insurance carrier for processing. However, in the situation of non-network coverage and/if the insurance company DOES NOT send reimbursement for services to the provider, the payments will be sent directly to you, the patient and/or subscriber. Orthopedic Sports Performance Institute will receive notification of payment status. In an effort to continue to provide you with the best care we can, we ask that you agree to the following:

(Initial the following statements in acknowledgement of your understanding and cooperation of each statement):

_____ Any correspondence with your individual insurance provider that relates to services performed by OSPI , should be brought to the office immediately so that we may reconcile your account. This correspondence may include, but are not limited to, Explanation of Benefits (EOB), checks/payments, denial of benefits letters, or requests for more information.

_____ If the documentation for your claim is not provided to our office, or in the event that you happen to cash the checks that are for services provided by OSPI , you will be responsible for the entire balance of the claim.

If you have any questions about this information, please feel free to sit down with a member of the staff and discuss how we may clarify and answer your questions.

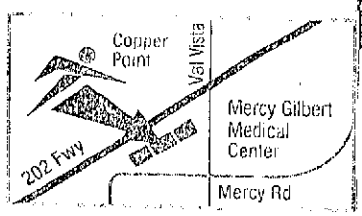
By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Name (please print): _____

Patient (or Legal Guardian's) Signature: _____ Date _____

Witness Name (please print): _____ Title: _____

Witness Signature: _____ Date: _____



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

HIPAA Notice of Privacy Practices – cont'd

YOUR RIGHTS

Following is a statement to your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

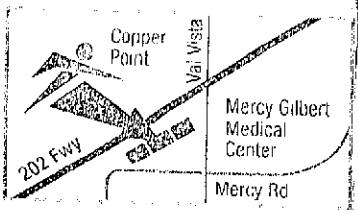
This notice was published and becomes effective on/or before **January 1, 2010.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Signature: _____ **Date:** _____

Print Name: _____



OSPI Orthopedic & Sports Performance Institute

480-899-4333
3530 S. Val Vista Dr. Suite B106
Gilbert, AZ 85297
www.ospiarizona.com

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health care information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health care information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make a disclosures to you and when required by
the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures will be made with your consent, Authorization or Opportunity to object unless required by law.

You may ***revoke this authorization***, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.