Towson Integrative Health
Patient Registration

Patient Name:_____ Social Security #_____-_____-_____
Last First Middle

Street Address:_____
Street City State Zip

Phone: (H)_____(W)_____(C)_____

Email:_____ Sex: M or F Birth date:____/____/____ Marital Status: S___M___D___W___

Occupation_____Employer's Name & Address___ _____

Emergency Contact_____
Name **Relationship** **Phone #**

Spouses Name: _____ Birth date___/___/____ SS#:_____ Employer_____

Referred By:_____ Primary Care Physician_____

Who is your Massage Therapist / Acupuncturist / Personal Trainer ?_____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Towson Integrative Health, and whomever they may designate as assistants, to administer Chiropractic and/or Physical Therapy care as deemed necessary to my _____ (relationship to parent), _____ (name of child). This consent will continue in effect until further notice.

I further give consent for Towson Integrative Health and whomever they may designate as assistants, to administer Chiropractic and/or Physical Therapy care as deemed necessary to my _____ (relationship to parent), _____ (name of child) with or without my presence during routine office visits _____ yes _____ no.

_____ _____ _____ _____
Print Guardian's Name Date Guardian's Signature Date

_____ _____
Witness Date

AUTHORIZATION TO DISCUSS PATIENT CARE

I authorize Towson Integrative Health to discuss my care with the following people: _____

Signature:_____ Date:_____

PAYMENT OPTIONS **PLEASE CIRCLE ONE**

#1 I will pay at time of service and in advance of any procedures, including co pays, coinsurances and deductibles as required by my insurance company.

#2 I prefer to be billed on my credit card for any charges relating to my care and treatment.

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

ACCOUNT # _____EXP DATE: _____SECURITY CODE_____

_____ _____
Signature Date

I understand that Towson Integrative Health will submit claims on my behalf to the appropriate insurance carriers using the information above. I am aware that it if my treatment is related to an auto accident or work comp injury it is my responsibility to also adhere to the guidelines of my Major Medical insurance so that in the event my personal injury case closes, my health insurance will be billed and I will be responsible for any co-payments, deductibles or non covered services.

Insurance Authorization

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Towson Integrative Health all medical benefits, if any, otherwise payable to me for services rendered. 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 to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

INSURANCE AUTHORIZATION OF TREATMENT

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered as a CASH patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I must pay deductibles, co pays and coinsurance at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of payment.
5. Towson Integrative Health (TIH) makes every attempt to receive authorization of treatment from insurance companies for treatment received at one of our facilities. However, there may be times when the insurance company does not provide this authorization in a timely manner. TIH will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, TIH will submit an appeal one (1) time. If the claim is not paid within 30 days of the appeal I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, (if supplied) to collect full payment, otherwise I must remit payment in full upon receipt of the bill.
6. If my account is turned over to collections, I agree to pay all court costs and 33% of attorney fees.

PATIENT RIGHTS AND RESPONSIBLITIES

You the patient have the right to:

- Be treated with dignity and respect
- Confidentiality
- Participate in the assessment and care planning process
- Be provided service in a timely manner
- Be notified in advance of types of treatment and frequency of treatment being provided
- Be notified of any changes in your plan of care and treatment
- Receive an explanation of the billing process and an explanation of charges
- Express grievance without fear of reprisal or discrimination
- Refuse or discontinue

You the patient are responsible for:

- Providing information when services are rendered
- Following the treatment plan as outlined by the doctor and scheduling for treatment at least 3 weeks in advance
- Notifying practice when you will not be available for treatment or will be late for treatment
- Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- Performing all the rehab exercises including the prescribed home care program as outlined by the doctor
- Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- Notifying the practice of any incident involving the staff or equipment
- Payment of all co-payment, coinsurance or deductible applicable per the insurance plan of your choice
- **Payment of a $25 missed appointment fee for appointments cancelled with less than 24 hours notice _____(initials)**
- **Make-up any cancelled visits that same week to avoid a missed appointment fee _____ (initials)**

CHIROPRACTIC CARE CONSENT AND WAIVER

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy, on me (or for the patient I am legally responsible) by the doctor of chiropractic employed by Towson Integrative Health or serving as back up for Towson Integrative Health in any office or facility.

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

I have read, or have been read to me, the above consent. I have also had the opportunity to ask a question about its consent, and by signing below I agree to the above-named procedures and policies. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition in which I seek treatment. **Finally, information collected on this form or in the treatment process may be used in its raw data form (no mention of patient name) to analyze for research purposes.**

Print Name_____

Signature _____ **Date** _____

Witness:_____ **Date**_____

AUTHORIZATION FOR THE DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996, Towson Integrative Health may not use or disclose your health information except as provided in our Notice of Privacy Practices without your AUTHORIZATION. Your signature on this form indicates that you are giving permission for the use and disclosure described herein. (Purposes of payment, referrals, and authorizations) You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to our office.

AUTHORIZATION SECTION

I, _____ hereby authorize the use and disclosure of the following health information that pertains to me for the purposes of payment, authorization, and referrals.

I authorize the following persons to make **and** receive these disclosures of my health information:

1. Primary Care Physician and other Treating Physicians
2. Attorney
3. Health Insurance Company/Health Insurance Commissioner
4. Towson Integrative Health

I understand that information disclosed to the authorization may be disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Towson Integrative Health. I further understand that any such revocation does not apply to the extent that persons authorized to use and disclose my health information have already acted in reliance on the authorization.

I understand that this authorization will not expire as use of the personal health information is being used for payment purposes.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to receive treatment, my eligibility for benefits will not depend on whether I sign this authorization or not.

I understand that I have the right to inspect and to obtain a copy and any information disclosed pursuant to this authorization.

I understand that Towson Integrative Health will receive compensation for the uses and disclosures that I have authorized.

_____ _____
Signature Date

_____ _____
Witness Date

REVOCATION SECTION

I hereby revoke this consent.

_____ _____
Signature Date

CONSULTATION FORM

Patient Name: _____ DOB: _____ M or F

Are you Pregnant or nursing? **Y or N** Do you have a pacemaker? **Y or N**

Have you ever had? Motor Vehicle Accident / Sports Injury / Work Injury / Slip and Fall Injury

Reason for today's visit_____When did the symptoms first appear?_____

What makes the symptoms worse or increase?_____

What makes the symptoms better or decrease?_____

In what position do you sleep? Back / Side / Stomach Do you sleep with a pillow? **Y / N** How Many? _____

Does this condition interfere with your sleep? **Y / N** If so, how many times do you wake up in pain at night?_____

Have you been treated for these symptoms or this condition before? **Y N** If yes, when? _____

By Whom ? _____

Have you had x-rays or MRIs taken recently? **Y N** Where?_____

The symptoms are:

☐ constant	☐ mild	☐ sharp	☐ dull	☐ achy
☐ frequent	☐ moderate	☐ burning	☐ stiffness	☐ swelling
☐ occasional	☐ severe	☐ numbness	☐ tingling	☐ other_____

REVIEW OF SYSTEMS

Do you have or have you ever had:

- Any generalized symptoms such as weakness, fatigue, fever, chills, night sweats, fainting, change in sleep pattern, unexplained weight loss, unexplained weight gain or others? YES NO
  If yes, please explain_____
- Any skin problems such as rashes, itching, dryness, sores, changes in skin color, changes in moles, changes in hair, changes in fingernails, or others? YES NO
  If yes, please explain_____
- Any lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood, or others? YES NO
  If yes, please explain_____
- Any heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain, cold extremities, high/low blood pressure, or others? YES NO
  If yes, please explain_____
- Any gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, change in appetite/thirst, change in stools or others? YES NO
  If yes, please explain_____
- Any genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others? YES NO
  If yes, please explain_____
- Any musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others? YES NO
  If yes, please explain_____
- Any neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others? YES NO
  If yes, please explain_____
- Any psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others? YES NO
  If yes, please explain_____
- Any eye, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others? YES NO
  If yes, please explain

Past Medical History

Please check (✓) to indicate if you have had any of the following: Self Left Box / Family Right Box

S	F		S	F		S	F		S	F	
☐	☐	AIDS/HIV	☐	☐	Cancer	☐	☐	Gout	☐	☐	Multiple Sclerosis
☐	☐	Stroke	☐	☐	Alcoholism	☐	☐	Cataracts	☐	☐	Heart Disease
☐	☐	Mumps	☐	☐	Suicide Attempt	☐	☐	Anemia	☐	☐	Chicken Pox
☐	☐	Hepatitis	☐	☐	Osteoporosis	☐	☐	Thyroid Problems	☐	☐	Anorexia
☐	☐	Diabetes	☐	☐	Hernia	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Appendicitis	☐	☐	Drug Abuse	☐	☐	Herpes	☐	☐	Pneumonia
☐	☐	Tuberculosis	☐	☐	Arthritis	☐	☐	Emphysema	☐	☐	High Cholesterol
☐	☐	Polio	☐	☐	Tumors	☐	☐	Asthma	☐	☐	Epilepsy
☐	☐	Kidney Disease	☐	☐	Prostrate Problems	☐	☐	Typhoid Fever	☐	☐	Blood Disorders
☐	☐	Fractures	☐	☐	Liver Disease	☐	☐	Psychiatric Care	☐	☐	Ulcers
☐	☐	Breast Lump	☐	☐	Glaucoma	☐	☐	Measles	☐	☐	Rheumatoid Arthritis
☐	☐	Vaginal Infections	☐	☐	Bronchitis	☐	☐	Goiter	☐	☐	Migraines
☐	☐	Rheumatic Fever	☐	☐	Venereal Disease	☐	☐	Bulimia	☐	☐	Gonorrhea
☐	☐	Mononucleosis	☐	☐	Scarlet Fever	☐	☐	Whooping Cough	☐	☐	High Blood pressure

Please list any major illness, injuries, or surgeries

HOSPITALIZATIONS, ILLNESS, INJURY,SURGERY	DATE	TREATMENT

Please list any allergies: _____

Please list any medications you are currently taking: _____

Please list any vitamins/nutritional supplements you are taking: _____

SOCIAL HISTORY

Please check (✓) all that apply.

☐ Married	☐ Never Smoked	☐ Exercise None	☐ No Alcohol	☐ Soda
☐ Single	☐ Previously Smoked	☐ Light Exercise	☐ Beer	☐ Coffee / Tea
☐ Divorced	☐ Presently Smoke	☐ Moderate Exercise	☐ Wine	
	☐ Pack/wk_____	☐ Heavy Exercise	☐ Liquor	
	☐ Years_____			

I WISH... NAME 3 THINGS THAT YOU WISH YOU COULD DO WITHOUT PAIN:

1._____ 2._____ 3._____

Please read the questions carefully and answer each one honestly by circling yes or no.

Yes	No	1.	Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
Yes	No	2.	Do you feel pain in your chest when you do physical activity?
Yes	No	3.	In the past month, have you had chest pain when you were not doing physical activity?
Yes	No	4.	Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes	No	5.	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Yes	No	6.	Is your doctor currently prescribing drugs (i.e., water pills) for your blood pressure or heart condition?
Yes	No	7.	Do you know of any other reason why you should not do physical activity?

Signature:_____ Date:_____

Towson Integrative Health

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.
EXAMPLE:

			headache		neck					low back		
no pain												worst possible pain
0	1	2	3	4	5	6	7	8	9	10		

##########

1. What is your pain RIGHT NOW?

no pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

2. What is your TYPICAL or AVERAGE pain?

no pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

What percentage of your awake hours is your pain at its worst? _____%

PRINT NAME _____ **AGE**_____ **DATE**_____
SCORE_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)