THRIVE
SPINE & SPORTS REHAB

PERSONAL INFORMATION

Name:_____ **Date:** _____

Birth Date:_____ **Age:**_____ **Marital Status:** S / M / D / W **Sex:** M / F

E-Mail Address:_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____ **Phone #:**_____

Employer:_____ **Occupation:**_____

In Case of Emergency Notify:

Emergency Contact: _____ **Phone #**:_____

How were you referred to our office? _____

Patient Medical History

Referring Doctor: _____ **Phone #:**_____

Family Doctor: _____ **Phone #:**_____

Reason for Today's Visit?_____

Is this condition related to a Motor Vehicle Accident or Workers Compensation? YES / NO

Describe Your symptoms: _____

When and how did it start? _____

What makes it better? _____ **worse?** _____

Have you been treated for this condition in the past? YES / NO

If yes, what treatments have you had?

_____

Do you have any questions or concerns about being treated?

_____

Sports Participation: Yes / No If **yes**, please circle:

Golf Tennis Football Soccer Baseball Basketball Running Wrestling Lacrosse

List any other sports you play: _____

List Current Medications:

_____

_____

Past Medical History: Please Circle and specify when necessary

Diabetes *Type: 1 2*	High Cholesterol	Anemia	Liver disease / Hepatitis
Depression / Anxiety	High blood pressure	Coronary artery disease	Gastric reflux
Scoliosis	Congestive heart failure	Kidney disease	Lymes disease
Rheumatoid / Osteoarthritis	Bleeding disorder	Seizures	HIV / AIDS
Stroke : *When?*	Heart Attacks: *When?*	Multiple sclerosis	Asthma
Cancer : _____	Vascular disease	Thyroid disease	COPD

Please list any medical conditions you may have that are not listed above:

_____

Family Medical History:	Diabetes	Thyroid Disease	
Bleeding disorder	Coronary artery disease	Hepatitis	Cancer
Heart disease/attacks	Seizures	Strokes	Lung disease
Rheumatoid arthritis	Asthma	Scoliosis	Multiple sclerosis

Other conditions not mentioned above:_____

Past Surgical History*: Please specify* **Date**

Joint replacement *specify*: _____	
Spine surgery : (cervical / thoracic / lumbar)	
Other Joint / Orthopedic Surgery:	
Abdominal Surgery :	
Cardiac Surgery :	

Please list any other surgery you may have had that is not mentioned above:

_____

Please Circle:

Are you currently pregnant? Yes / No

Do you have any allergies? Yes / No If **yes** please specify: _____

Do you smoke? Yes / No If **yes**, how much do you smoke? _____

Do you drink alcohol? Yes / No If **yes**, how frequent? Social only / Several times per week / Everyday

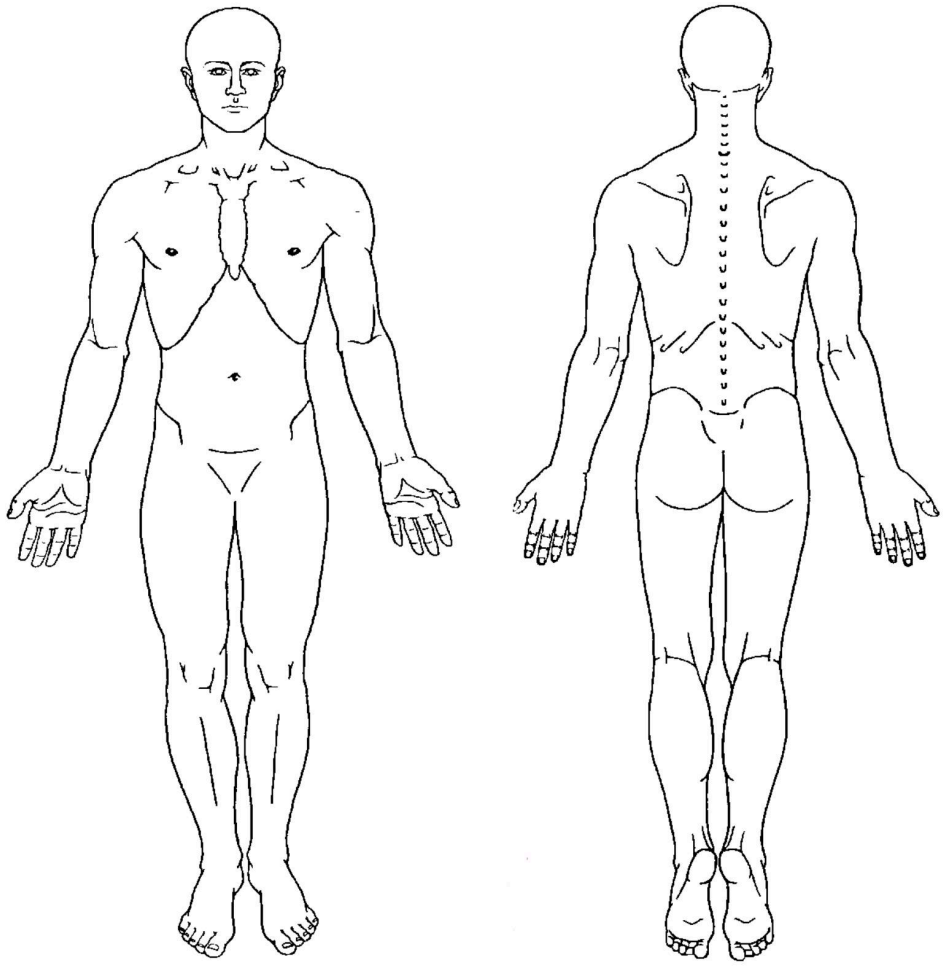
Do you or have you used illicit drugs? Yes / No

If **yes**, what kind? Marijuana Pills Other:_____

Pain Diagram

Please mark below what symptoms you are having in the corresponding place on the body

P = Achy pain N = Numbness B = Burning S = Sharp Pain T = Tingling Pain



(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

I attest that the information provided above is accurate and complete to the best of my knowledge.

Patient Signature:_____ Date:_____

Assignment of Benefits

I irrevocably assign to Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC all my rights and benefits under any insurance contracts for payment for services rendered to me by Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC to be released to Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC. I irrevocably authorize THRIVE Spine and Sports Rehab, LLC/THRIVE Point, LLC to file insurance claims on my behalf for services rendered to me. I receivable directed that all such payments go directly to Thrive Spine Sports rehab, LLC/THRIVE point, LLC. I irrevocably authorized Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This agreement of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature:_____ **Date:**_____

Financial Policy Agreement / Assignment of Benefits

Thank you for choosing Thrive Spine Sports rehab, LLC/THRIVE point, LLC as your healthcare provider. We always drive to provide optimal care to all patients and we do everything we can to help achieve this goal. Thrive Spine and Sports Rehab, LLC/THRIVE point, LLC is a private professional entity not contracted with any insurance plans with the exception of Medicare. Even though we do not participate in your plan's network, we pledge to help you understand and manage the financial aspects associated with providing you the best care possible.

Insurance plans allow patients to select their own treating physician, even if that physician is not contracted within that plan's network. To help you understand your responsibilities, we will contact your insurance to gather information regarding your out of network coverage, and explain what financial obligations you will have for our services. Due to the fact that we are an out of network facility, your treatment plan will not be limited by what an insurance company plan representative will approve, but it will be determined by the recommendation made by one of our board certified practitioners with the sole intent of improving your way of life.

All charges will be submitted to your insurance company on your behalf as an out of network provider. You may be responsible for your deductible and coinsurance on allowed payments up to your out of network maximum according to your plan out of network plans coverage. Most insurance plans allow a reasonable and customary payment for services rendered at Thrive Spine Sports rehab, LLC/THRIVE point, LLC, in which case you will not receive any bills. In a few cases, however, your plan may not provide reasonable and customary payments for services rendered, and in that case, you may be responsible for some of the difference between what is billed and what your insurance allows for payment.

Some insurance companies may send a payment for services directly to you. You agree to relinquish all payments that you receive from your insurance company for services rendered at Thrive Spine Sports Rehab, LLC/THRIVE Point, LLC. Failure to do so will result in legal action.

Patient Signature:_____ **Date:**_____

Financial Agreement for Cash Patients

- **Payment responsibility:** I understand that as a cash paying patient, I am responsible for the full payment of all services received at the time they are rendered, unless other arrangements have been made in advance.
- **Payment methods:** I agreed to pay for services rendered using the following acceptable forms of payment;
  - ■ **Cash** ■ **Credit card** ■ **Debit card**
- **Collection procedures:** I understand if I fail to pay for services rendered, the practice reserves the right to pursue collection actions, including reporting unpaid balances to credit bureaus and/or collection agencies. I agree to be responsible for any associated collection costs.
- **No refunds:** I understand that buying a cash package means that I will not receive a refund on any unused appointments. Packages are already discounted, so therefore no exceptions will be made.
- **Agreement acknowledgment:** I have read and understand the terms of this financial agreement. By signing below, I agree to abide by these terms and accept responsibility for all charges incurred for services rendered.

Patient Signature:_____ **Date:**_____

Appointment Cancellation and No Show Policy

Thank you for trusting your medical care to Thrive Spine Sports Rehab / Thrive Point. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment, please contact our offices as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation, and no-show policy below:

- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office for at least 24 hours notice will be considered a "no-show" and charged a fee of ½ the cost of the self-pay rate for your scheduled services. The fee is charged to the patient, not the insurance company and is due at the time of the patient's next office visit.
- As a courtesy, you do receive a reminder, text for appointment appointments. If you do not receive a reminder the above policy will remain in effect. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience circumstances, please contact our office manager, who may be able to waive the no-show fee.
- Messages left at either location are acceptable.

I have read and understand the medical appointment, cancellation, and no-show policy and agreed to its terms.
Patient Signature: _____ Date: _____

Privacy Notice

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclose how you can get access to this information. Please review it carefully.

Your Rights: you have the right to;

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those whom we've shared your information
- Get a copy of this privacy
- Choose someone to act on your behalf
- File a complaint if you believe your privacy rights have been violated

Your Choices: you have some choices in the way we use and share information as we;

- Tell family and friends about your condition
- Provide disaster relief
- Market our service services

Our Uses/Disclosures: Thrive Spine Sports rehab, LLC/THRIVE, LLC may use/share your information as we;

- Treat You
- Run our organization
- Bill for your service
- Help with public health and safety
- Do research
- Comply with the law
- Respond to organ and tissue donation
- Work with a medical examiner or funeral
- Address, workers, compensation, law-enforcement, and other government
- Respond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the notice of privacy practices, if requested.

Patient Signature:_____ **Date:**_____

Informed Consent For Treatment

Please read the entire document prior to signing it. It is important that you understand the information contained below.

The Nature of the Adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. It may cause an audible "pop", Much like you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedure;

- Spinal manipulative therapy
- Vital signs
- Orthopedic test
- Muscle strength test, Range of motion test
- Radiographic studies
- Palpation
- Basic neurological testing
- Postural analysis testing

The Availability and Nature of other treatment options

Other treatment options for your condition may include;

- Self administered, over-the-counter analgesics and rest
- Medical care and prescription drugs, such as anti-inflammatory, muscle, relaxant, and painkillers
- Hospitalization
- Surgery

If you choose to use one of the above noted other treatment options, you should be aware that there are risks and benefits of such options, and you may wish to discuss these with your primary care provider.

The risks inherent in adjustments

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious implications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the doctor's attention. It is your responsibility to inform the doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of bone which is checked during your history/examination and/or x-ray. Stroke and/or arterial dissection caused by CHIROPRACTIC neck manipulation has been the subject of ongoing medical research and debate. The most current research of the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow adhesion formation and reduce mobility, which may cause pain reactions further reducing mobility. Over time this may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and or physical therapist and or occupational therapist, and have my questions answered to my satisfaction. By signing below, I stated that I have weighed the risks involved in the treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of my risks, I hereby give my consent to that treatment.

Patient Name:_____ **Date:**_____

Patient Signature: _____ **Date:**_____

Informed Consent For Acupuncture

I , _____, hereby authorize, the licensed acupuncturist, Thrive Spine Sports, rehab, LLC/THRIVE point, LLC to administer any type of oriental medicine, relevant to my diagnosis and treatment, including, but not limited to the following;

- Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- Massage technique called "gua sha" may produce redness to the skin, which remains for 1 to 5 days. A slight bruising or tenderness may persist following the treatment.
- Cupping may be used to promote blood circulation through the body cups may produce a red/purple color on the area cut which may remain for 1 to 5 days
- Electrical stimulation may be used which produces a vibration/tapping sensation on the needles.
- Infrared, he may be applied to an area to help promote blood flow. This can cause redness in an area.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with treatment, and was given the opportunity to ask questions about my treatment. Although acupuncture is a safe modality and side effects are rare, I understand. There is always a possibility of unexpected complications and no guarantee can be made concerning the results of the treatment.

Patient Signature:_____ Date:_____

Reviewed by Physician: _____ Date:_____

Card on File Authorization Form

Patient Name: _____
Date of Birth: _____

Card Information

☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover

Cardholder Name: _____

Card Number: _____

Exp Date: _____ CVV: _____

Authorization

I authorize Thrive Spine & Sports Rehab of Belmar to keep my card on file and charge it for services rendered, including copays, deductibles, self-pay services, missed appointment fees, or balances not covered by insurance.

This authorization remains in effect until revoked in writing.

Cardholder Signature: _____
Date: _____

Consent to Treat a Minor

Patient Information:

- Name of Minor: _____
- Date of Birth: _____
- Address: _____

Parent/Guardian Information:

- Name of Parent/Guardian: _____
- Relationship to Minor: _____
- Contact Number: _____

Consent Statement: I, the undersigned, hereby give my consent for the above-named minor to receive medical treatment as deemed necessary by the healthcare providers at ***Thrive Spine and Sports Rehab***. I confirm that I have the legal authority to provide this consent.

Emergency Contact:

- Name: _____
- Contact Number: _____

Signature:

- Signature of Parent/Guardian: _____
- Date: _____

Witness (if required):

- Signature of Witness: _____
- Date: _____