PILM

ABOUT THE PATIENT

PILM, 3963 West Royal Drive, Traverse City, MI 49684

Name _____ Today's Date_____ Birthdate _____ Age_____ Gender _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ e-Mail Address _____

Significant Other's Name _____ Whom may we thank for referring you? _____

Your Employer _____ Type of Work _____

Emergency Contact _____ ph # _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Pathways Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
  - Relationship to patient: _____; phone number: _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins. ❑ Financing

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to _____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to _____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to _____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to _____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

_____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

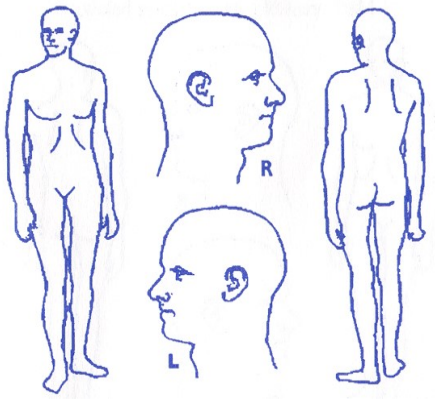
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

PILM, 3963 West Royal Drive, Traverse City, MI 49684

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking / Foot Drop	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Substance Addiction
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Dizziness	❑	❑	Fibromyalgia
❑	❑	Sleeping Difficulty	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:** _____

_____

2. **List any known allergies to medication:** _____

_____

2. **Please list all doctors you are currently seeing and their specialty:** _____

_____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?**_____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____

_____

8. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____

_____

ADDITIONAL HEALTH HISTORY

PILM, 3963 West Royal Drive, Traverse City, MI 49684

Indicate which of the below you have experienced in **the last 1-2 months**
1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Constantly

Eyes/Ears/Nose/Throat		Muscular/Skeletal		Neurological		General	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Stuffiness	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Lethargy	1 2 3 4 5
Sore Throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness	1 2 3 4 5
Persistent Cough	1 2 3 4 5	Back Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheaded	1 2 3 4 5
Chest Tightness	1 2 3 4 5	Neck Pain	1 2 3 4 5	Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Ear Pain	1 2 3 4 5	Wrist / Hand Pain	1 2 3 4 5	Pins / Needles	1 2 3 4 5	Constipation	1 2 3 4 5
Itchiness	1 2 3 4 5	Shoulder / Arm Pain	1 2 3 4 5	Forgetfulness	1 2 3 4 5	Diarrhea	1 2 3 4 5
Wheezing	1 2 3 4 5	Hip Pain	1 2 3 4 5	Feeling Foggy	1 2 3 4 5	Short Breath	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient / Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

PATIENT CONSENT FOR COMMUNICATION

PILM has the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our office may be contacted via phone/text messages to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Pathways Integrative and Lifestyle Medicine PC.
2. I consent to receive text messages from Pathways Integrative and Lifestyle Medicine PC at my cell phone. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: (_____) _____-_____.
3. I consent to receive email communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is: _____.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patient Name: _____ Signature: _____ Date: _____

HIPAA Compliance Form

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully, if you have any questions, please ask our Office Manager for clarification.

Uses & Disclosures

Disclosure of your protected health information without authorization is strictly limited to defined situations. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes; emergency care, quality assurance activities, public health, research, and any law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining consent. You may request restrictions on disclosure.

Apart from the above circumstances, any use or disclosure of your health information will be made only with your written authorization. Your written authorization may be revoked, in writing, at any time except to the extent that we have provided services or taken action in reliance on your authorization.

Your Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Your request to limit the use and/or disclosure of your health information must be made in writing to our Office Manager.

You have the right to inspect and receive copies of your records within 30 days of request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You have the right to request changes to your records. Our practice has the right to accept or deny your request.

You have the right to receive a copy of this Notice, upon request.

Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We maintain a history of protected health information disclosures that are accessible to you. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

We must abide by the terms of the Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice upon request.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe you privacy rights have been violated. We will not take any action against you for filing a complaint.

You may file a complaint with us by writing our Office Manager at the address that follows:
PILM, 3963 W Royal Dr, Traverse City, MI 49684

Patient Name: _____ Signature: _____ Date: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Pathways Integrative and Lifestyle Medicine PC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Name: _____ Signature: _____ Date: _____

PATIENT CONSENT TO TREAT

I hereby authorize the Doctor(s)/Nurse Practitioner(s) of Pathways Integrative and Lifestyle Medicine PC to treat my case as they deem appropriate through the use of lab testing, decompression, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation, nutritional support, medical evaluations, soft tissue injections, and diagnostic testing and imaging. I realize the goal of integrative medicine is to restore function to improve quality of life and not simply to reduce pain. The patient agrees that he/she is responsible for all bills incurred at this office.

Signature: _____ Date: _____

To be reviewed by provider:
I have reviewed all pages of the intake and recognize it to be complete and accurate to the best of my knowledge.
Provider Name: _____ Provider Signature: _____ Date: _____