ARC
American Rehab Connection
Acupuncture & Physical Therapy Specialist Inc.

Welcome to Our Practice!

Patient Information: **Today's Date:** _____

Name: (Last) _____ **(First)** _____ **(MI)** _____ **Date of Birth:** _____

Sex: Male or Female Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Mailing Address: _____ **City/State/Zip:** _____

Email Address (For communication purpose only): _____

Do you consent to Email/Text message communications ? □ No □ Yes

Emergency Contact? Name: _____ **Relationship:** _____
Home #: _____ **Cell #:** _____

Primary and Referring Doctor Information:

Primary Care Doctor: _____ Practice Name: _____ Phone Number: _____

Referring Doctor Name: _____Practice Name: _____ Phone Number: _____

Referral Source:

How did you hear about our clinic (please circle)? Doctor Referred Internet Search _____ Insurance Company Seminar/ Community Event _____

Other People: _____ Advertisement/Other _____

PATIENT CONSENT

Authorization for treatment

I hereby request and agree to be treated by ARC Physical Therapy & Acupuncture Spec.

Authorization for insurance billing and collection

I hereby authorize ARC Physical Therapy & Acupuncture Spec. to bill my insurance, including releasing information requested by the insurance company and other procedures necessary to collect the claims on my behalf.

Patient Signature_____ Date_____

Patient Privacy (HIPAA): ARC follows the Federal guidelines to protect your privacy. **NO** information will be released to any third party unless specified by you. Please **initial** here to acknowledge: _____.

Information Release: □N/A or □If you wish to release information to any party, please specify here:

I, _____ (print name), hereby authorize ARC to release my information to

_____.

Signature: _____, Date: _____

(ARC-HIPAA patient privacy policy is available upon request.)

Any future request to release information must be in writing addressed to ARC.*

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Medical History Form

Note: (official use only)

Patient Name_____**Date**_____

What is the primary condition you are coming for?_____

_____

_____

What is the Nature of this condition? (Please Circle)

CHRONIC SUDDEN/ONSET CHRONIC WITH ACUTE FLARE UP

Frequency of pain: CONSTANT MOTION TRIGGERED INTERMITTENT

When did the current condition/pain start?_____

What caused the condition? _____

_____

Was this due to an accident? YES NO **If yes, what kind? (**please circle)

FALL AUTO WORK HOME OTHER:_____ **date of the accident?** _____

Do you have any of the following? (please circle) X-RAY MRI CT-SCAN OTHER_____ **Do you have access to any of those?** YES NO

Are you using assistive devices? (Please Circle) CANE WALKER

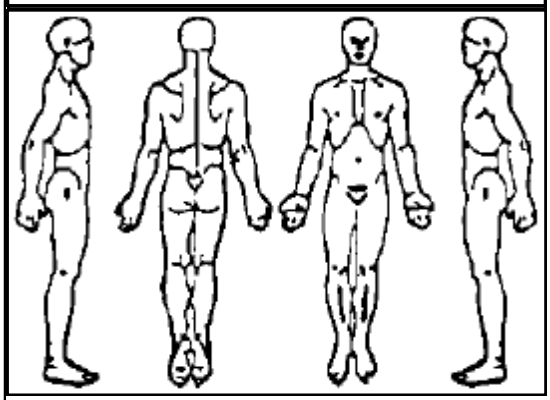
OTHER ASSISTIVE DEVICES _____

What does this condition interfere with? (please circle)

WORK DAILY ROUTINE SLEEP OTHER_____

PLEASE CIRCLE ALL THAT APPLY TO YOUR CONDITION: Type of Pain: SHARP DULL ACHING SHOOTING NUMBNESS PIN&NEEDLES NAGGING BURNING STABBING THROBBING CRAMPING OTHER:_____

If you are in pain, please MARK the exact location of your pain on the figure.



What makes your condition worse? _____

What makes your condition better? _____

Please list all medications you are currently using _____

_____

Please list all surgeries by type and year_____

_____

Please list all preexisting conditions you have_____

_____

_____

Do you have an electronically implanted device? YES NO Please describe: _____

PLEASE CIRCLE ANY THAT APPLY TO YOU:

Surgical Fusion Implant Joint Replacement HIV HEP A/B/C Pregnant Osteoporosis Anemia TB Epilepsy

Heart Disease Pacemaker High Blood Pressure Autoimmune Disorders Lupus Rheumatic Arthritis MS Diabetes

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Medical History Form Continued

Patient Name_____ **Date**_____

The purpose of this form is to detail what steps you have taken in treating the condition you are coming to us for and assess your current condition. Please answer everything to the best of your ability.

Have you had any of the following procedures for this condition? (please circle)

PAIN MANAGEMENT INJECTION MEDICATIONS CHIROPRACTIC ER VISIT NERVE BLOCKING/BURNING SURGERY (name of surgery)_____ OTHER_____

Have you ever had to have emergency care for this condition? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you ever received an injection for this condition? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you received pain management for this condition? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you ever had nerve blocking or burning? ? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you been prescribed medications for this condition? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you ever any other form not listed, of treatment for this condition? YES NO If yes, what kind?_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Have you had any surgery for this condition? YES NO **If yes, what kind?**_____

_____

How frequently? _____ **Was it Effective?** YES NO **How long did the results last?** _____

Were you recommended any surgery or invasive treatments for this issue, but have not had any yet? YES NO

if yes, please describe: _____

_____

What is your current pain level? Please circle: (1 is no pain at all, 10 being the worst, unbearable pain)

1 2 3 4 5 6 7 8 9 10

What is your pain level when taking medication? Please circle: (1 is no pain at all, 10 being the worst, unbearable pain)

1 2 3 4 5 6 7 8 9 10

What is your goal for treatment wit us? (Please Circle) SYMPTOM RELIEF ONLY ELIMINATION OF ROOT CAUSE STOP/PREVENT FURTHER DEGENERATION WHATEVER HELP I CAN GET

What is your pain tolerance? (please circle) VERY LOW LOW MODERATE HIGH VERY HIGH

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Financial Agreement

Please read carefully then Sign and Date: (Please feel free to ask for assistance if you have any questions!)

By Signing at the bottom of this agreement, you understand and agree to the following conditions:

Full responsibility of charges encountered for my treatments:

I understand that ARC will do their best effort to verify my insurance benefits information. It is, however, ultimately my personal responsibility to make sure the benefits information is correct for the reason that occasionally the insurance company gives incorrect information even with ARC's best effort. I have the right to verify the insurance information personally before any treatment is rendered. By signing this agreement, I hereby trust ARC's best effort and will be fully responsible and personally guarantee all expenses encountered for all my treatments by ARC.

Treatment with best effort by ARC, Result can not be guaranteed

I understand that the results of medical interventions, including those provided by ARC, can vary widely by individual. ARC will, under no circumstance, guarantee the full resolution of my conditions. I understand that ARC will approach my conditions with best effort I agree to be liable for all charges disregard of the treatment result.

Assignment of Benefits (Payments made to the claims filed by ARC will be assigned to ARC, including those sent to me by my insurance directly related to the claims filed on my behalf of treatments rendered by ARC.)

I hereby assign and transfer any and all rights, benefits, and causes of action to the Assignee, Acupuncture & Physical Therapy Specialist, Inc. *dba* ARC Physical Therapy & Acupuncture Spec. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, and the company fails or refuses to make timely, complete payment, I authorize the Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize the Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

Direction of Payment (Direct my Ins. Co. to pay ARC directly)

I hereby authorize and direct my insurance company to pay directly to ***Acupuncture & Physical Therapy Specialists Inc, dba*** *(the Assignee)* such sums as may be due and owing Assignee for the services rendered to me both by reason of accident or illness and by reason of any other bills that are due to the Assignee. I hereby authorize any insurance company to pay directly to the Assignee the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company involved in this case.

I have read and agreed with the above statements; hereby the undersigned:

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date