Absolute Wellness, PLLC

Dr. Ingrid Johnson-Rodriguez MSR, DC, PMA-CPT

Patient Information

Full Name:_________________________________ Date:____/____/______

Preferred Name:________________________ Date of Birth____/____/______

Street Address:_________________________________ ☐ Female ☐ Male

City:_________________________ State:_______ Zip Code:______________

Primary Phone:_____________________________ Type: Home Cell Work

Secondary Phone:___________________________ Type: Home Cell Work

Email Address:_____________________________

Emergency Contact Information

Emergency Contact:__________________________ Phone:_______________

Relationship:_______________________________

Referral Information

How did you hear about our office? Please circle one of the following, and name the source in the space provided.

Physician Current Patient Attorney Family/Friend CrossFit/Gym Health Fair/Race Google
Yelp Groupon Facebook Other:

____

Insurance Information

Insurance Company:________________________

Member ID:_______________________ Group Number:__________________

Consent for Treatment

Assignment and Release: By singing below, I authorize Absolute Wellness, PLLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Absolute Wellness, PLLC, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by singing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By singing below, I give my consent for examination and the performance of any test or procedures needed. If patient is a minor, by singing I give consent for examinations, tests, and procedures for the above minor patient.

Signature:____ Date_______________

Health History

Please Check the Box if You have Had any of these Conditions:

☐AIDS/HIV	☐Cancer	☐ High Cholesterol	☐Parkinson's Disease
☐Alcoholism	☐Chest Pain	☐ Implant	☐Pinched Nerve
☐Allergy Shots	☐Depression	☐ Kidney Disease	☐Pneumothorax
☐Anemia	☐Diabetes	☐ Liver Damage	☐Polio
☐Appendicitis	☐Digestive Problems	☐ Loss of Balance	☐Prostate Problems
☐Arthritis	☐Dizziness	☐ Lung Problems	☐Rheumatoid Arthritis
☐Asthma	☐Epilepsy	☐ Migraines	☐Ringing in the Ears
☐Bleeding Disorder	☐Glaucoma	☐ Multiple Sclerosis	☐Stroke
☐Blurred Vision	☐Heart Disease	☐ Osteoporosis	☐Thyroid Problems
☐Breast Lump	☐Hepatitis	☐ Pacemaker/Simulator	☐Tumors

☐Other:____

Current Medical Doctors/Alternative Doctors:____

Surgeries:____

Illnesses/Injuries/Hospitalizations:____

Medications:____

Vitamins/Supplements:____

Allergies:____

Are You Pregnant? ☐ Yes ☐ No **Due Date:**__________________

Tobacco: ☐Cigarettes ☐Cigars ☐Smokeless **How Often?** ☐Daily ☐Weekends ☐Occasionally ☐Never

Alcohol: ☐Daily ☐Weekends ☐Occasionally ☐Never

Recreational Drug Use: ☐ Daily ☐Weekends ☐Occasionally ☐Never

Exercise: ☐Daily ☐2-3 times per week ☐ 1 time per week ☐Never

Caffeine: ☐Daily ☐Weekends ☐Occasionally ☐Never

High Stress Level: ☐Yes ☐ No **Reason:**___________________________

Specify the Approximate Date of your Most Recent Exams (month/day):

Physical Exam:	_______/_______	Dental X-Ray:	_______/_______
Spinal X-Ray:	_______/_______	CT Scan:	_______/_______
MRI:	_______/_______	Other Scans or X-Rays:	_______/_______

Please Describe the Reason for Your Visit:____

____

____

Date Symptoms Began:____/____/_______ **Date of Most Recent Flare-Up:**____/____/_______

How did the Injury Occur?:____

Symptom Frequency (circle one): 25% or less 26%-50% 51%-75% 76%-100%

Symptom Timing: (circle one and indicate same, better, or worse)

Same All Day Better/Worse in the Morning Better/Worse Midday

Better/Worse at the End of the Day Better/Worse at Night

Describe your Pain or Discomfort (circle all that apply)

Aching Burning Cramping Deep Dull Sharp Throbbing Tingling Stabbing
Numbness Radiating Stiffness Swelling Shooting Other:_______________

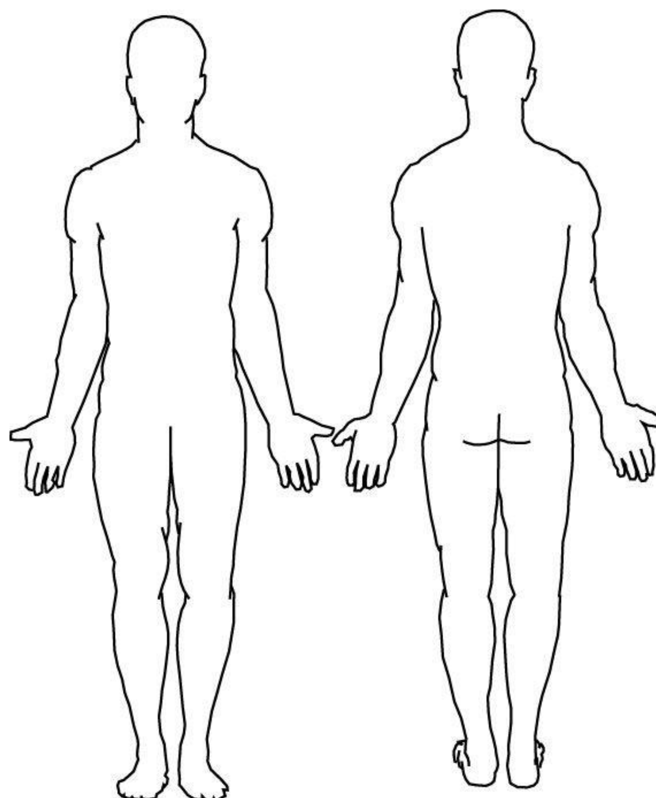
Which Activities Worsen your Pain or Discomfort. (circle all that apply)

Sitting Standing Walking Bending Lifting Sleeping Sneezing Coughing Reaching
Twisting Looking Up Looking Down Driving Typing House Chores Exercise Lying Down
Other:_____________________________________

Which Activities Relieve your Pain or Discomfort? (circle all that apply)

Sitting Standing Lying Down Knees Bent Up No Movement Movement Heat Ice
Analgesic Topical Ibuprofen Medication Rest Stretching/Exercise
Other:_____________________________________

Please mark an X on the picture where you feel discomfort or pain:



Authorizations and Releases

Name:____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultations, assistants, or designees to render care of treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am a legal guardian of the child, and grant my consent for a treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

*Initial:*____________

Consent to Interpret X-Rays

I agree that this practice may seek outside interpretation of my x-rays by a qualified professional not empoloyed by this practice. I agree that any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

*Initial:*____________

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health care plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

*Initial:*____________

Financial Obligations

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where in my liability is limited by contract of State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney for collection, I shall pay fees, including, but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health coverage

You may direct any questions regarding this financial obligation to the clinic manager or physician

*Initial:*_____________

Signature:____ Date:____/____/_________