INBOX FUNCTIONAL REHAB

PATIENT INFORMATION

Patient's Name: _____ Gender: ____ D.O.B. ____ / ____ / _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Phone: (_____) _____ - _____

How did you hear about InBox? _____

Employer or School Name: _____

Emergency Contact: _____ Day Phone: (_____) _____ - _____

Financial Responsibility

In return for services rendered to me by the InBox Provider, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

OUT-of-NETWORK status I understand that InBox Functional Rehab has an Out of Network status with all insurance providers. I will be responsible for payment of services rendered at time of appointment. It is my responsibility to contact my health plan provider to aaccess self-claim forms and other information. Any reimbursement from services rendered will be solely my responsibility to attain.

MEDICARE I acknowledge that InBox is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Statement of Understanding

At the time of your initial visit, an InBox Provider will explain and educate you on InBox's treatment services, including the use of manual therapy techniques and active care. After this explanation, if you do not want to receive InBox's services, then you are free to leave without obligation of payment. After the explanation, if you elect to receive InBox's services, then you will be treated, and you and/or your insurance company will be responsible for payment for all services. By signing below, you acknowledge that you understand the information described in this paragraph.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) Date

No Show/Cancellation Policy

Your InBox Treatment Team understands there may be circumstances which require you to cancel or reschedule an appointment, but our requirement is that you notify our office **more than 24 hours before your scheduled appointment**. After one (1) "No Show" or two (2) "Less than 24 hours notice for cancellations", you will be limited to only **Same Day Scheduling** appointments. **Same Day Scheduling** means you can call in the morning to check for same day appointment availability.

To assist you in keeping your scheduled appointments, you will receive a reminder notification prior to your scheduled appointment.

Please acknowledge you have read and understand this policy by signing below.

_____

Signature of Patient or Guardian

InBox Functional Rehab, LLC

INFORMED CONSENT TO TREATMENT

Event Name (if applicable): _____

Doctors of chiropractic and physical therapists who use manual therapy techniques such as the manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy (ice), and occasional spinal adjustments should advise patients that there are or may be risks associated with such treatment. In particular you should note the following risks or complications:

A. **Manual Therapy, Myofascial Release:**

Explanation and Benefits: Manual therapy and myofascial release involve a licensed health care provider's hands applying pressure on muscle tissue and manipulating joints. In particular, myofascial release involves the gentle sustained pressure into the myofascial connective tissue restrictions. The benefit of manual therapy and myofascial release is to restore normal tissue function, joint function, and aid in normal musculoskeletal biomechanics. Manual therapy and myofascial release have been shown to decrease patient reported pain levels, speed recovery, and restore range of motion.

Risks: The risks of manual therapy and myofascial release include localized discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), symptoms shifting to different body areas, post treatment soreness, or an increase in pain.

Alternatives: The alternatives to manual therapy and myofascial release include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

B. **Active Rehabilitation Exercises:**

Explanation and Benefits: Active rehabilitation exercises are designed and prescribed for the sole purpose of facilitating appropriate mobility or stability within the musculoskeletal system. Such rehabilitation exercises include, but are not limited to, functional movements, stretches, self-myofascial release, and open and closed chain exercises.

Risks: The risks of active rehabilitation exercises include aggravation of a present condition, blood pressure changes, and increased heart rate.

Alternatives: The alternatives to active rehabilitation exercises include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

C. **Kinesio-Taping:**

Explanation and Benefits: Kinesio-taping is the specialized taping of areas of the body. Kinesio-taping may aid normal muscle movement and provide stability by mimicking the effects of bracing.

Risks: The risks of kinesio-taping include skin reactions, itching, allergic reactions, hyper pigmentation (discoloration), and blistering.

Alternatives: The alternatives to kinesio-taping include: icing, bracing, athletic taping, and ace bandaging.

D. **Cyrotherapy (ice):**

Explanation and Benefits: Cryotherapy is the exposure to subzero temperatures to decrease inflammation. Cryotherapy can aid in decreasing muscle soreness, stiffness, swelling and bruising.

Risks: The risks of cryotherapy include skin reactions, itching, allergic reactions, burning, hyper pigmentation (discoloration), and blistering.

Alternatives: Alternatives to cryotherapy include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

E. **Cervical Spine Adjustments:**

Explanation and Benefits: Cervical spine adjustments are the thrusts applied to the vertebra utilizing parts of the vertebra and contiguous structures as levers to directionally correct articular malpositions and improve or correct subluxation. The benefits of cervical spine adjustments include correction of vertebral subluxations, increased stability, and decreased pain.

Risks: The risks of cervical spine adjustments include, but are not limited to, pain and discomfort, fractures, strokes, dislocations, sprains, and injury to a vertebral artery. Vertebral artery injuries may cause strokes, sometimes with serious neurological impairment, and on rare occasion result in death. The possibility of such serious injuries resulting from cervical spinal adjustment is extremely remote.

In addition, the nature of your injury may require the InBox provider(s) to perform treatment near or around sensitive areas (*e.g.*, chest, groin, buttocks, etc.). The InBox providers will make every effort to safeguard your modesty and appropriately conceal the area.

The informed consent documents are used to communicate information about the proposed treatment along with disclosure of risks and alternative forms of treatment. The informed consent documents should not be considered all-inclusive in describing methods of care and all potential risks. Your InBox provider may provide you with additional or different information, which is based on the facts in your particular case and the current state of medical knowledge.

I understand that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment including, but not limited to the risks described above. Knowing that I have a condition requiring treatment, I voluntarily consent to treatment performed by an InBox provider (including spinal manipulation). Although the treatment is usually beneficial and seldom causes problems, I understand and have been informed of the potential risks. I have been informed about the methods used by the InBox providers, I and have had the opportunity to ask questions and express concerns prior to treatment. I do not expect my InBox provider to be able to anticipate and explain all risks and complications of my treatment. Further, I wish to rely on the professional and clinical judgment of my InBox provider during the course of my treatment.

I have read and fully understand the above statements. I authorize InBox personnel to administer treatment as deemed necessary. I intend this consent to apply to all my present and future care.

Minor Consent: *If applicable, I have the legal right to select and authorize healthcare services for the minor child named below, and I authorize an InBox Provider to perform the treatment as outlined above to this minor.*

TO BE COMPLETED BY PATIENT OR PATIENT'S LEGAL REPRESENTATIVE:

Patient's Name: _____

Patient's Signature: _____

Name of Patient's Legal Representative (if applicable): _____

Signature of Patient's Legal Representative (if applicable): _____

Date Signed: _____/_____/_____ *Patient's Date of Birth:* _____/_____/_____

CURRENT PROBLEM & MEDICAL HISTORY

Patient's Name: _____ Referring Doctor: _____

Chief Complaint: Injury is on the: ☐ Right Side ☐ Left Side ☐ Both Sides

Please describe your injury and the purpose of your visit: _____

_____

Mechanism of Onset:

How did your injury happen?
- ☐ Gradual/Over Time
- ☐ Traumatic/All of a Sudden
- ☐ Don't Know
- ☐ Chronic

How long ago did it happen?
- ☐ Less than 14 days
- ☐ 2 weeks to 12 weeks
- ☐ 12 weeks to 1 year
- ☐ More than 1 year

For Work-Related Injuries:

Specific Injury Date: _____/_____/_____

Work Status: _____

For THIS injury only: **Please rate your pain** (0=no pain - 10=worst pain ever). Circle one: **0 1 2 3 4 5 6 7 8 9 10**

Please rate your level of pain and/or dysfunction: ☐ None ☐ Very Little ☐ Moderate ☐ Significant ☐ Extreme Pain

When does your injury cause you pain?
☐ Constantly ☐ On and Off

What time of day does your injury cause you pain?
☐ Morning ☐ Afternoon ☐ Night

What best describes your pain?
- ☐ Ache ☐ Sharp
- ☐ Burning ☐ Shooting
- ☐ Dull ☐ Stabbing
- ☐ Numbness ☐ Throbbing
- ☐ Radiating ☐ Tingling

What best relieves your pain?
- ☐ Medication ☐ Rest
- ☐ Heat ☐ Activity
- ☐ Cold/Ice ☐ Nothing

What makes your pain worse?
- ☐ Standing ☐ Activity
- ☐ Sitting ☐ Other _____
- ☐ Rest

Sleep Disturbances: ☐ Difficulty Falling Asleep ☐ Difficulty Finding Comfortable Position ☐ Awakened by Pain

Prior Treatment for This Injury:

			Comments:
Have You Had Surgery for This Injury?	☐ Yes	☐ No	_____
Have You Seen a Specialist For This Injury?	☐ Yes	☐ No	_____
Were You Hospitalized For This Injury?	☐ Yes	☐ No	_____
Were You Advised to Have Surgery For This Injury?	☐ Yes	☐ No	_____
Any P.T. or Chiropractic Care For This Injury?	☐ Yes	☐ No	_____# of Visits

Medications: Are you taking any Medication for THIS Injury? ☐ Yes ☐ No

Please list all other Medications that you are taking below:
- ☐ Pain
- ☐ Steroids
- ☐ Diabetic
- ☐ Antidepressant
- ☐ Allergy
- ☐ Muscle Relaxers
- ☐ Blood Thinners
- ☐ Cholesterol
- ☐ Anti-inflammatory
- ☐ Cardiac
- ☐ Hypertension
- ☐ GI Tract

Please comment on any other medications not listed:
_____
_____
_____
_____
_____

Diagnostic Tests: Did you have any Diagnostic Imaging performed for THIS Injury? ☐ Yes ☐ ■ No

- ☐ MRI
- ☐ Bone Scan
- ☐ EMG
- ☐ EEG
- ☐ CT Scan
- ☐ X-Ray
- ☐ Nerve Conduction
- ☐ Bone Density Scan

Please comment on any **positive** diagnostic test(s):
_____
_____
_____

Medical Conditions: Please indicate any of the following medical conditions you have experienced with THIS injury.

- ☐ Fracture
- ☐ Muscle Tear
- ☐ Tendon/Ligament Tear
- ☐ Obstructive Edema
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Warm Inflamed Skin
- ☐ Active Hemorrhage
- ☐ Localized Infection

PERTINENT MEDICAL HISTORY

Medical Condition

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Shortness of Breath
- ☐ Prostate
- ☐ Birth Defects
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Kidney Stone
- ☐ Hypoglycemia
- ☐ Hernia
- ☐ Rheumatic Fever
- ☐ Heart Attack
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Gall Bladder Disease
- ☐ Bronchitis
- ☐ Anemia
- ☐ Lung Disease
- ☐ Stroke
- ☐ AIDS/HIV+
- ☐ Bone or Joint Disease
- ☐ Gout
- ☐ Meningitis
- ☐ Sinus Infection
- ☐ Migraine Headaches
- ☐ Recurrent Headaches
- ☐ Multiple Sclerosis
- ☐ Irregular Heartbeat
- ☐ Pancreatitis
- ☐ Seriously Depressed
- ☐ Unexplained Weight Loss
- ☐ High Blood Pressure
- ☐ Venereal Disease
- ☐ Colon Infection
- ☐ Cancer
- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Trouble
- ☐ Diabetes

Allergies

- ☐ Seasonal _____
- ☐ Food _____
- ☐ Latex _____
- ☐ Other _____

Lifestyle Activities

Hobbies: _____

Sports: _____

Other Physical Activities: _____

FOR WOMEN ONLY

Please fill in the number of: ____ Pregnancies _____ Births _____Children

Please give any additional information on any difficult pregnancies, delivery complications, and/or menstrual problems:

_____

_____

Prior to Treatment

Is there anything else your provider should know about your condition prior to treatment? _____

_____

PATIENT SIGNATURE

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) **Date**

Do not write below. For InBox Provider use only:

_____

_____

_____

_____

_____

_____

Release of Medical Information & Records

Patient's Name: _____ Date of Birth ____ / ____ / _____

By signing below I authorize InBox Functional Rehab, LLC to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, communicating with my referring physician, and any administrative operations related to treatment or payment as noted in InBox's Notice of Privacy Practices. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I understand that InBox will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I retain the right to revoke this consent by notifying the practice in writing at any time. In addition, I am authorizing InBox to communicate my personal health information to the following individual(s), organization, or employer as I have written below:

_____

_____

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) Date