GREENAPPLE sports & wellness

Confidential Patient Information

Please write your legal name on all paperwork

Date_____

Name_____ Date of Birth_____

Address_____City_____State_____Zip Code_____

Home Phone _____ Work Phone _____

Cell Phone _____ Email_____

Social Security #_____-_____-_____ Gender ☐ Male ☐ Female

Occupation_____Employer Name_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Spouse or nearest relative_____Phone number_____

Who referred you to our office?_____

INSURANCE INFORMATION

Name of Insurance Co_____ Name of Insured_____

Insured Employer_____ Insured Date of Birth_____

Are you covered by more than one insurance company? ☐ Yes ☐ No Name_____

Is your visit today regarding a Work Injury or Car Accident? ☐ Yes ☐ No

Over

This form is designed to inform you in advance of our policies for payments, insurance, claims, and third party payment responsibilities. Please refer any questions the you may have to the front desk receptionist. Please read, initial, and sign below.

_____Payment for co-pays, co-insurance and deductibles is expected at time of service. We accept cash, check, Visa, MasterCard, and Discover. A $35.00 service charge will be applied to all returned checks. Payment for any returned check must be in cash and include the $35.00 fee.

_____Insurance is a contract between you and your insurance company. As a courtesy to you, we will bill your insurance carrier. You are responsible for any and all co-pays, co-insurance, and deductibles.

_____A summary of the Privacy Practice (HIPAA) has been made available to me and I understand my rights. By way of my signature, I provide Greenapple Sports & Wellness with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payments and health care operations as described in Privacy Notice.

_____At Greenapple Sports & Wellness our major concern is to assist you in maintaining overall good health. However, your insurance may only approve the visits necessary to improve your symptoms. Once we have reduced your symptoms your insurance company may no longer pay for any additional care. Often it is beneficial for the patients to continue supportive care. In such case, you, the patient may be financially responsible.

_____We are happy to provide treatment for accident victims and those involved in liability cases. All information must be given to our office immediately following the accident. You must provide us with and and all attorney, liability, medpay, and health insurance information.

_____In case of minors, it is the responsibility of the accompanying legal guardian to approve in advance and pay for treatments. The guardian is also responsible for making sure the patient account is kept current.

I have read and understand the above information. By signing below I consent to treatment and agree to the terms listed above.

_____ _____

Patient Signature **Date**

Release & Assignment

TO MY INSURANCE CARRIER:

1. I authorize the release of any information necessary to process my insurance claims.
2. I authorize and request payment of medical benefits directly to my physician named below:

Greenapple Sports and Wellness 4601 Park Road Suite 100 Charlotte, NC 28209 Phone 704-527-7246 Fax 704-527-3080

3. I agree this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this document may be used in lieu of the original.

Patient Name:_____ Date:_____

Patient Signature _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

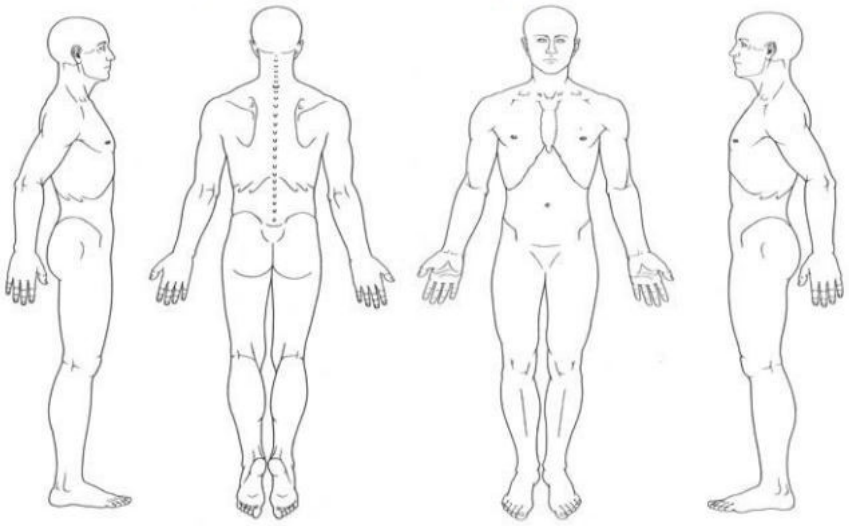
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Average pain intensity:

Last 24 hours:	**no pain**	0	1	2	3	4	5	6	7	8	9	10	**worst pain**
Past week:	**no pain**	0	1	2	3	4	5	6	7	8	9	10	**worst pain**

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

8. ***Have you had similar symptoms in the past?*** ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

9. ***What is your occupation?***

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

Patient Signature _____ **Date** _____

Turn Over →

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer			
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances				○	○	
○	○	Dizziness	○	○	Asthma	○	○	
			○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Missed Appointments and Late Cancellation Policy

Thank you for choosing Greenapple Sports and Wellness for your chiropractic care. Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. In order to provide the highest quality services to our patients, we have enforced a Missed Appointment Policy. We understand there are times when you must miss a medical appointment due to emergencies. However, missed appointments impact the flow of patients in our clinics.

Please review the following agreement and sign at the signature line, indicating that you understand our policy.

Our no-show and cancellation policy applies to missed appointments, which include:

- **No-show: You don't arrive for your appointment, and you don't reach out to cancel.**
- **Late cancellation: You cancel your appointment less than 24 hours before your appointment time.**
- **Late reschedule: You reschedule your appointment less than 24 hours before your appointment time.**

You will be subject to a **$60.00** charge for any missed or cancellations not within the 24 hour period.

You can help us ensure all patients have the appointment access they need by:

- Arriving on time for your appointments.
- Understanding that if you arrive 15 or more minutes after your appointment time, we may need to reschedule your appointment.
- Notifying the clinic at least 24 hours in advance if you cannot make it to your appointment.

Missed appointments due to unforeseen emergency situations, such as medical emergencies or illness, ***may*** be considered an exception to the policy and will be at the discretion of the practice manager on a case-by-case basis.

As a patient or guardian for a patient receiving services from Greenapple Sports and Wellness, I understand and agree with the following:

Patient Name_____

Patient/Guardian Signature_____

Date_____

CHIROPRACTIC TREATMENT AND ITS RISKS

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and X-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand-guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, exercise and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stoke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.

As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

Unusual Risks

If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable (contra-indicated), your chiropractor will explain the risks to you and answer any questions you may have.

Patient Name: _____ **Patient Signature:** _____

Dr. Signature: _____ **Date:** _____

DRY NEEDLING CONSENT TO TREAT FORM

Dry Needling (DN) involves inserting a tiny monofilament needle into symptomatic tissue with the intent to reduce pain, increase circulation and improve function of the neuromusculoskeletal system. DN is not traditional Chinese Acupuncture, but instead is based on neurology, physiology and western medical principles. DN is a valuable treatment for musculoskeletal pain; however, like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and/or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- Are you taking blood thinners? Yes / No
- Are you or is there a chance you could be pregnant? Yes / No
- Are you aware of any problems or have any concerns with your immune system? Yes / No
- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____ authorize the performance of Dry Needling.
(print name)

_____ _____
Patient Signature Date

_____ _____
Relationship to patient (if other than patient) Date

I was offered a copy of this and refused.

***Dry needling is a non-covered service. Treatments are $50.00 per visit.**