

# ACTIVE LIFESTYLES WELLNESS & PERFORMANCE CTR.

chiropractic, physical therapy & nutritional counseling

*We thank you for choosing our facility for your wellness needs. It is very important to us to deliver the best possible care to you and to all our clients. In trying to do so, we ask that you follow the plan of care given to you which includes your home exercise program and your scheduled appointments.*

*We strongly value timeliness in our office and we try to minimize waiting periods. We realize that your time is just as valuable as ours. Therefore we would like for you to respect our 24 hour cancellation policy so we can schedule appointments most efficiently.*

*We value your business and the business you provide us with your referrals. If you are satisfied with our services, we encourage you to refer a friend or a loved one or write us your testimonial. Also, if you have any suggestions on how to improve our services please let us know.*

*Our mission is to provide the best care possible through chiropractic, physical therapy, massage and supplement (vitamin)/nutritional therapy. We also make foot orthotics in this practice to help correct foot misalignments and restore normal pain free foot function. It is a comprehensive type practice and we encourage you to explore all we have to offer.*

***We strongly recommend you fill out all the forms attached and return them fully completed prior to your appointment. Unlike other offices, we are usually punctual and we therefore ask for your cooperation. Having the paperwork out of the way facilitates this. Also, we recommend you provide us with all imaging (X-Ray, MRI CT scan) reports in your possession relevant to your current complaint or have the office that has them forward it to us. If you are consulting us for nutrition, we ask for all relevant bloodwork results. If you are coming in for massage, realize that a timeframe is reserved for you. If you are late, this will cut into your massage time.***

***If you have been involved in a motor vehicle accident or in a workman's compensation accident and/or are currently or will be seeking legal help for your difficulties, please let us know prior to scheduling an appointment with us.***

*We look forward to serving you.*

*Best wishes of Health,  
Your Healthcare Team at Active Lifestyles.*

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**OFFICE USE Only:** BP \_\_\_/\_\_\_ Weight \_\_\_ lbs. Pulse \_\_\_ bpm Height: \_\_\_ Temp: \_\_\_  
Primary Insurance: \_\_\_\_\_ Secondary: \_\_\_\_\_ Co-Pay: \$ \_\_\_\_\_

***To save time and allow us to better serve you, please complete ALL questions on the next pages. Thank you!***

Personal History

## **Balance ONLY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F   
E-Mail: \_\_\_\_\_ Social Security # \_\_\_\_\_

Type of Work performing currently or performed in the past: \_\_\_\_\_

Circle One: Married Single Widowed Divorced Separated Other Number of Children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_

### ***Current Health Condition***

Current Complaint(s): **Balance Problem/Coordination.**

Other doctors seen for this condition?  Yes  No Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

Is it getting:  Worse  Constant  Comes/Goes  Better

How often have you fallen, tripped or stumbled this past year? \_\_\_\_\_

How long have you been using such device: \_\_\_\_\_

If so, when: \_\_\_ at home, \_\_\_ when I leave the home only, \_\_\_ all the time.

Are you totally independent at home to dress, bathe, cook meals, and do house chores? No \_\_\_\_, Yes \_\_\_\_

Do you wear hearing aids?  Yes  No

Can you see well?  Yes  No

Do you have normal sensation in your feet?  Yes  No

**Compare this problem at its worst and a time when you feel great. How does this problem interfere with:**

Your ability to work? \_\_\_\_\_

Your ability to enjoy your family or your social time? \_\_\_\_\_

Your ability to enjoy your hobbies or sports? \_\_\_\_\_

At its worst, how old does this problem make you feel? \_\_\_\_\_

Have you had X-rays/ MRIs/ CT scans taken in the last six months? NO. If yes, where? \_\_\_\_\_

**Send us /bring your reports prior to or on the day of your appointment.**

**How far did you walk/run for exercise prior to the injury? \_\_\_\_\_miles/day Now? \_\_\_\_\_miles/day**

**Do you use assistive devices (canes, walkers, braces, and orthotics)? How long? \_\_\_\_\_**

**What is your functional goal in therapy/chiropractic? \_\_\_\_\_**

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### ***Past Health History***

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  
 Other: \_\_\_\_\_

Orthopedic Surgeries/Injuries: 1.Head:\_\_\_\_\_Neck:\_\_\_\_\_

2. Upper Extremity: \_\_\_\_\_

3. Back: \_\_\_\_\_

4. Lower Extremity: \_\_\_\_\_

Previous: Motor Vehicle Accidents: \_\_\_\_\_ Work Injuries: \_\_\_\_\_

Hospitalization (other than above): \_\_\_\_\_

### **Past Treatment History**

Other doctors/ physical, occupational, massage therapists/ acupuncturists, seen **for this current condition?**

Who? \_\_\_\_\_ Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

**Who else?** \_\_\_\_\_ Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

**Chiropractic Care/ Physical Therapy (FOR SIMILAR or OTHER CONDITIONS in the past)**

Have you ever had **Chiropractic Care** or **Physical Therapy** (circle one or both if yes)? **NO**

If Yes, **When?** \_\_\_\_\_ **Where?** \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

Results: Excellent Good Fair Poor Chiropractic or Physical Therapy Technique used: \_\_\_\_\_

### **Medical Doctor/ Medical Practitioner**

Name: \_\_\_\_\_ Date of Last Appointment: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

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**Insurance Coverage. Please answer the questions below (do not list your insurance coverage here).**

**1. Are you currently under the care of a home health aide? YES / / NO / /**

**NOTE: If you are receiving HOME HEALTH services now or in the future while still coming to this office, Medicare will not cover your services here and you will be responsible for all non-covered charges.**

**2. Have you had any Chiropractic or Physical therapy services this calendar year? YES / / NO / /**

**3. Are you seeking legal counsel or advice for this case? YES/ / NO / /**

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## Past Family History

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Please indicate any health issues that are present in your family and that you suffer from too:

Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

## Medication and Supplement History

If you will be providing us with a written or typed list, do not complete the table below.

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>When did you start taking</u>

<u>Supplement Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>When did you start taking</u>

Would you be interested in using vitamin supplements customized for your particular needs and/or to help counter-act the side-effects of your medications? \_\_\_\_ YES \_\_\_\_ NO

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**Check any of the following you have had in the past six months:**

**Nervous System**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Depression
- Fainting
- Convulsions
- Cold / Tingling Extremities
- Stress

**Musculo-Skeletal**

- Low Back Pain
- Gas/Bloating After Meals
- Pain between Shoulders
- Heartburn
- Neck Pain
- Black/Bloody Stool
- Arm Pain
- Colitis
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

**C-V-R**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**EENT**

**Vision Problems**

- Dental Problems
- Sore Throats
- Ear Aches
- Hearing Difficulties
- Stuffed Nose

**Genito-Urinary**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**Gastro-Intestinal**

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Abdominal Cramps

**Check any of the following diseases you have had:**

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema

**General**

- Fatigue
- Loss of Sleep
- Fever
- Headaches
- Significant Weight Loss

**Females Only**

When was your last period?  
\_\_\_\_\_

Are you pregnant?

- Yes
- No
- Not Sure

**Male / Female**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

**Lifestyle Stress Levels**

- High
- Moderate
- Very Little

**Intake**

- Coffee (cups per day : \_\_)
- Tea (cups per day: \_\_)
- Alcohol: \_\_glasses/week
- Cigarettes: \_\_/wk., for \_\_/years
- White Sugar
- Street Drugs: \_\_\_\_\_

**Satisfaction with Diet**

- Satisfied
- Somewhat satisfied
- Dissatisfied

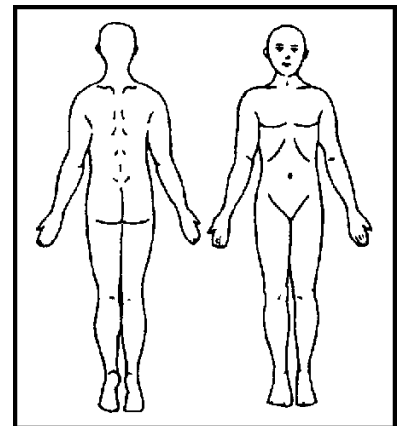
**Did you exercise just prior to this injury?**

Yes. How many times per wk?

Walk: \_\_ Run: \_\_ Swim: \_\_ Gym: \_\_

Golf: \_\_ Tennis: \_\_ Other: \_\_\_\_\_

No



*Please outline on the diagram the area of your discomfort and any radiation of pain.*

## **COMPENSATION FOR SERVICES**

In consideration of services rendered by the physicians at Active Lifestyles W & P ctr, which may include, but not be limited to, chiropractic care, acupuncture, physical therapy, massage therapy, strength training protocols/programs, or nutritional therapy I recognize that I am responsible for the fees associated with my care.

I understand that my insurance coverage may not cover all my charges and therefore I will be required to cover any gap created. A health insurance policy is an agreement between a policyholder and an insurance company and any disagreement regarding coverage must be determined between the parties. Active Lifestyles W& P ctr is therefore not responsible for settling policy disputes. Our office will be responsible for preparing notes, billing receipts and informal reports as needed to aid in insurance payment/reimbursement.

## **BENEFITS, RISKS, ALTERNATIVES**

There are many approaches to health care. You are here today seeking our expertise in the way we approach health issues and you can be assured that your case will be managed to the best of our ability. The benefits of chiropractic care, acupuncture, physical therapy, massage therapy, strength training, and nutritional therapy are well documented in research. Although there can be great benefits inherent in any of the above modalities, the patient must also be informed that there may be risks involved as well. Those risks, although in our opinion minimal, may manifest themselves in post therapy soreness/stiffness/tenderness, sprains/strains, dislocations, fractures, disc injuries, strokes, allergic reactions. Your alternatives may include; no care, allopathic care, naturopathy, acupuncture, etc. It is impossible for the doctor/ therapist to foresee every complication or risk that may be possible. You are encouraged to ask your doctor any questions you may have regarding any therapy proposed.

Although the human organism has a biological framework similar from one to the next, each individual is unique. Results may therefore vary. No guarantee of improvement or success can be made.

For pregnant females: In the event radiographs are recommended you are advised to inform the doctor and/or radiologist of the date you began your last period and/or pregnancy.

## **Office Policies**

**We try our best to get you well, but like any good relationship, cooperation and communication is a must. We therefore ask you:**

- 1. Respect the appointment time given to you. For cancellations, we expect a call 24 hours ahead of your scheduled appointment for Tuesday through Friday appointments and Friday before 4 pm for Monday appointments. I understand there is a missed appointment fee of \$40 if this is not respected.**
- 2. Follow the recommendations given to you with respect to exercise and activity levels.**
- 3. Communicate all concerns and problems you may encounter with treatment with your therapist/ chiropractor at the next visit.**

Witnessed by my signature below, I hereby certify that I am above the age of 18 and or emancipated, and have read the above in its entirety, recognize/agree to its content and hereby **CONSENT FOR TREATMENT** today and all future visits.

My Printed Name \_\_\_\_\_ My Signature \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_

## Regular Fee Schedule (FOR THE MOST COMMON PROCEDURES ONLY)

Code	CPT	Description	Fee
<b>Physical Therapy</b>			
<b>PT Eval 3</b>	97163	Evaluation level 3	\$125
<b>PT Eval 2</b>	97162	Evaluation Level 2	\$80
<b>PT Eval 1</b>	97161	Evaluation Level 1	\$75
<b>PT ReEval</b>	97164	Re-evaluation	\$80
<b>M-Ther</b>	97140	Manual Therapy 1+ regions	\$47.04 (per 15 min.)
<b>Chiropractic</b>			
<b>OV5</b>	99205	Office visit level 5	\$436.82
<b>OV3</b>	99203	Office visit level 3	\$228.60
<b>OV1</b>	99201	Office visit level 1	\$91.16
<b>SM</b>	98940	Spinal manipulation 1-2 regions	\$56.98
<b>SM3</b>	98941	Spinal manipulation, 3-4 regions	\$84.44
<b>SM5</b>	98942	Spinal Manipulation, 5 regions	\$108.58
<b>MX1</b>	98943	Manipulation Extraspinal, i.e. Extremities	\$57.82

### Therapies used in Chiropractic and Physical therapy (per 15 minutes)

<b>Gait</b>	97116	Gait Training Therapy	\$44.52
<b>THER-EX</b>	97110	Therapeutic Exercise	\$49.98
<b>NEURO</b>	97112	Neuromuscular re-education	\$51.46
<b>THER-ADL</b>	97530	Therapeutic Activities of daily living	\$52.00

### Modalities used in Chiropractic and Physical therapy (per area)

<b>E-STIM</b>	G0283	Electrical Stimulation Therapy	\$21.68
<b>Hot/Co</b>	97010	Hot/cold pack therapy	\$13.08
<b>US</b>	97035	Ultrasound Therapy	\$21.60

### Other services/ equipment usually not covered by Insurance

<b>Elect</b>	A4556	Electrodes for Therapy (4)	\$10.00
<b>Ex-band</b>	A9300	Exercise Band	\$12.00
<b>NUT-AD</b>	97802	Medical Nutritional Advice, initial	\$150
<b>NUT-F/U</b>	99803	Medical Nutritional Advice follow-ups per 15 mins.	\$40
<b>LAZ</b>	S8948	Laser treatment	\$50

### MISSED or Cancelled Appointment (less than a 24 hour notice)

**\$40 (cannot be billed to insurance)**

I understand that this is not a complete list of all the fees associated with this office and moreover, that insurance may not cover all these fees. Furthermore, I realize that I am ultimately responsible for paying all fees associated with my treatment here at Active Lifestyles Chiropractic, regardless if insurance pays for them or not. A complete fee schedule may be provided upon request.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Office staff witness)

\_\_\_\_\_  
(Date)

Revised September 12, 2018

ACTIVE LIFESTYLES WELLNESS & Performance CTR.

HIPAA Notification Protocol

I, \_\_\_\_\_, would like any and all communication with Active Lifestyles Wellness & Performance Center, LLC including, but not limited to, lab test results, diagnostic test results, appointment confirmation, financial account information, missed appointments, to be carried out in accordance with my instructions listed below. I further stipulate that a message may be left on the voicemail ready numbers written below.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Please provide your contact details in the order you wish our office to attempt to contact you:

\_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_ Cell Ph: \_\_\_\_\_

\_\_\_\_\_ Business Ph: \_\_\_\_\_

In the event that any notification attempts made by Active Lifestyles W&P Center are unsuccessful, I grant them permission to have the information verbalized to the following people:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

**Patient Signature**

\_\_\_\_\_

**Today's Date**

1715 37<sup>th</sup> Place, Third Floor

Vero Beach, Florida 32960

Telephone 772-978-7379

Fax 772-539-8515