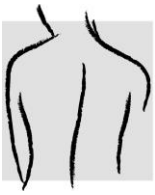


Cole Pain Therapy Group

Relieving pain. Restoring lives.

Today's Date / /

Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Preferred Name** _____

Last Name _____ **Middle Name** _____ Suffix _____

Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____

Mobile Phone _____ *We provide text-based appointment confirmations.*

Primary email _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method *(check one)* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone

Date of Birth / / **Age** _____ **Sex** *(check one)* ❑ Male ❑ Female

SSN _____ **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Spouse _____ Phone _____ Spouse Date of Birth _____

Your Employment Status *(check one)* ❑ Employed ❑ Other ❑ FT Student ❑ PT Student

Your Employer _____ Phone _____

Emergency Contact _____ **Phone** _____

Relationship to You _____

Primary Physician _____ Referred By _____

May we thank the individual who referred you and/ or send a summary report to your primary care physician and/ or referring doctor? ❑ Yes ❑ No

Race ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian ❑ Other _____ ❑ I choose not to specify

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language ❑ English ❑ Spanish ❑ Other_____

Continued…

To be performed by office staff:

Height: _____ inches **Weight:** _____ **BP:** _____/ _____ **O_2 Sat:** _____ **Pulse:** _____ **Resp:** _____

Patient's name _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known.

If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

_____

Has any doctor diagnosed you with hypertension (high blood pressure) presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

What is your level of willingness to make nutrition and/or dietary changes to improve your health?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Continued…

Cole Pain Therapy Group

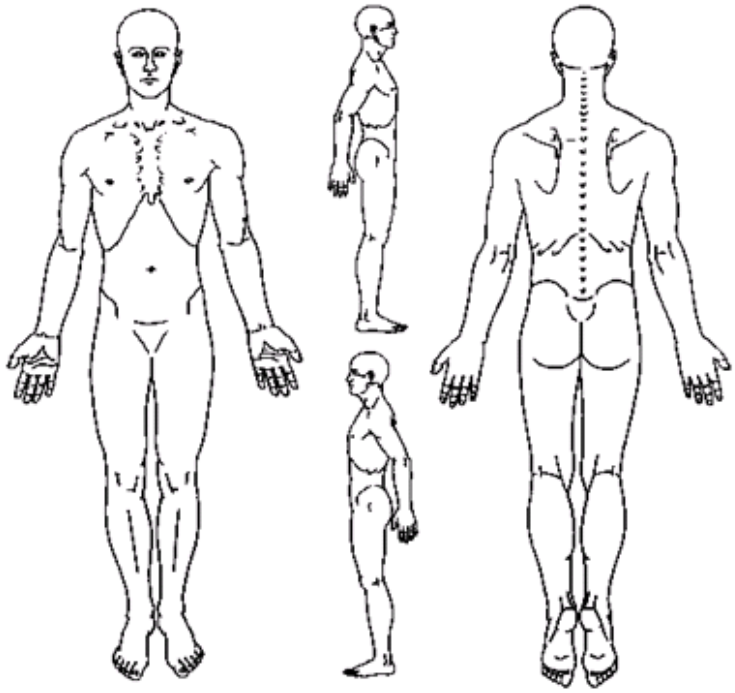
Relieving pain. Restoring lives.

Patient's name _____ **Date** _____

SYMPTOM DRAWING

Please mark the location of your symptoms on the diagram to the right with the following letters:

N	numbness	X	burning
S	stabbing	P	pins and needles
A	dull ache	O	pain



PAIN SCALE

Please rate your pain on the following scales for each area of pain.

Example:

No Pain 0 1 (2) 3 4 (5) 6 (7) 8 9 10 Worst Possible Pain

HEADACHE BACK KNEE

1. What is your pain level RIGHT NOW?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

2. What is your TYPICAL or AVERAGE pain level?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

3. What is your pain level AT ITS BEST (how close to 0 does it get at its best)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

4. What is your pain level AT ITS WORST?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Continued…

Patient's name _____

Please put a check "✓" next to all symptoms you have experienced **in the last month**.

- ❑ Weight loss or gain
- ❑ Poor appetite or overeating
- ❑ Trouble falling or staying asleep
- ❑ Feeling tired/ fatigue
- ❑ Sleeping too much
- ❑ Trouble concentrating
- ❑ Feeling restless/ fidgety
- ❑ Night sweats
- ❑ Cold hands or feet
- ❑ Fever
- ❑ Chills
- ❑ Rash
- ❑ Skin wound (cuts or puncture)
- ❑ Headaches/ migraines
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Vision problem
- ❑ Falling down
- ❑ Difficulty with balance
- ❑ Loss of smell
- ❑ Limb weakness
- ❑ Numbness
- ❑ Dizziness
- ❑ Fainting
- ❑ Memory lapses or loss
- ❑ Feeling nervous
- ❑ Anxiety
- ❑ Sinus pressure
- ❑ Difficulty swallowing
- ❑ Cough
- ❑ Difficulty breathing
- ❑ Chest pain or discomfort
- ❑ Abdominal pain
- ❑ Change in bowel habits
- ❑ Diarrhea
- ❑ Blood in bowel movement
- ❑ Constipation
- ❑ Heartburn
- ❑ Lump in throat
- ❑ Pain during urination
- ❑ Changes in urinary habits
- ❑ Muscle cramps
- ❑ Neck stiffness
- ❑ Back stiffness
- ❑ Muscle aches
- ❑ Joint pain, swelling, stiffness
- ❑ Easy bruising tendency

If you have **ever been diagnosed** with any of the following, please mark it with a check "✓."

- ❑ Cancer
- ❑ Stroke
- ❑ Depression
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Osteoporosis
- ❑ Lupus
- ❑ Fibromyalgia
- ❑ Rheumatoid Arthritis
- ❑ Autoimmune disease
- ❑ Thyroid disease
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ Hepatitis

Physician Notes

Authorization to File Insurance **Patient Name**_____

I authorize Cole Pain Therapy Group (CPTG) to release any information it deems appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by CPTG or any member of the staff acting on CPTG's behalf.

Assignment of Benefits

I authorize the direct payment to CPTG of any sum I now or hereafter owe CPTG by any insurance company obligated to reimburse me and by my attorney, out of the proceeds of any settlement of my case for the charges for services rendered or otherwise obligated to make payment to me or CPTG, based in whole or in part upon the charges made for services rendered. In the event any insurance company obligated by contractual agreement to make payment to me or to CPTG for the charges made for services rendered refuses to make such payment upon demand by CPTG, I hereby assign and transfer to CPTG the cause or action that exists in my favor against any such company. I authorize CPTG to prosecute said action either in my name or the name of CPTG as CPTG deems necessary. I further authorize CPTG to compromise, settle, or otherwise resolve said claim as CPTG deems necessary.

Financial Agreements

If an insurance company obligated to pay me or CPTG the charges for services rendered refuses to pay upon demand by CPTG, or if there is no insurance company so obligated, then I will pay for services rendered by CPTG. I understand that my health insurance is my responsibility and that it is my duty to obtain referrals for care when necessary. I promise to pay for services rendered to me and not covered by my insurance company by my lack of obtaining a referral. CPTG will use due diligence in obtaining authorizations to treat and pre-certification when necessary in order to render care, and I will pay for services rendered on my behalf that were not covered by my insurance carrier because pre-certification or insurance authorization was not granted by my insurance company. I will pay my account in full or will keep my account current. If I have a liability claim, I hereby promise to keep my account current and then pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two months from the date of discharge, whichever comes first.

ERISA Authorization

I hereby designate, authorize, and convey to CPTG to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from CPTG and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

Late Payments

I will be allowed two (2) months to pay CPTG the balance on my bill. If I do not pay within this time period CPTG will add a 1.5%, or minimum $8.00 billing fee to my monthly unpaid balance. I agree to pay all cost of collections if my account becomes delinquent, including attorney fees and all court costs if a lawsuit is filed against me.

I have read your authorization agree to its terms. I am also acknowledging that I have received a copy of this form.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Name of Insured _____ Date _____

Witness _____ Date _____

Patient Name _____

Privacy Notice

We are very concerned about protecting your privacy. While the law requires us to give you this disclosure, please understand that we have respected, and always will respect, the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital as it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

You have a right to review our privacy policies in detail prior to signing this form. A copy is available at the offices of Cole Pain Therapy Group. We reserve the right to change our privacy practices as described in that notice.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before receiving your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information, if they decide to contest any of your claims.

I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this form.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____

Patient Name _____

Consent to Examine and Treat

The undersigned consents to any examination including, but not limited to, physical, orthopedic, and neurological evaluation, radiographic (x-ray) examination, visual inspection, palpation, exercise stress test, electromyography (EMG), electrocardiograph (ECG), and photography/videography.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, massage, trigger-point therapy, ultrasound, electrical therapy, traction, muscle stretching, heat/ice application, nutritional supplementation, acupuncture, dry needling, and rehabilitative exercise.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help also may do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include and are not limited to: pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures. I am also acknowledging that I have received a copy of this form.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____