Solutions Patient Information

Name ______________________________ Date of Birth: ______________ Today's Date: ______________

SSN: ______________________ Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Work Status: Employed ☐ Student ☐ Retired ☐ Other ☐

Employer: ____

Whom may we thank for referring you? ______________________________________

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐

Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Ethnicity: Hispanic or Latino yes ☐ no ☐

Primary Language: ________________ Email: ____

Address: ____

City: ________________________________ State: ________________ Zip Code: ____________

Main Phone:__________________________________ Cell ☐ Home ☐ Work ☐ Other ☐

Other Phone: ________________________________ Cell ☐ Home ☐ Work ☐ Other ☐

Emergency Contact: ____________________________ Phone: _________________________

Guardian name____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ____________________

Parent or Guardian Date

Do you have Primary Medical insurance? Yes ☐ No ☐

Do you have Secondary Medical insurance? Yes ☐ No ☐

Relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

If you did not check 'Self', please provide information below:

Name of Insured: ____

Insured's Date of Birth:______________________ Insured's SSN: ____________________________

Insured's Gender: Male ☐ Female ☐

Insured's Employer: ____

Employer Address: ____

Solutions Patient Information

Name ______________________ Date of Birth: ____________ Today's Date: ____________

Employer:______________________________ Occupation: ______________________

Height: __________Weight: __________ Shoe Size: ________Shoe Width: reg □ wide □

Use of Alcohol, Tobacco, Drugs? (list type, frequency or amount): ______________________

____

Daily Requirements: Walking □ Lifting □ Sitting □ Standing □ Other □ ______________

Allergies: ____

Previous Hospitalizations / Surgeries / Serious Illnesses Approximate Date Hospital or City & State

______________________________ ____________ ______________________

______________________________ ____________ ______________________

Previous: Motor Vehicle Accidents Broken Bones Knocked Unconscious Stitches?

______________________________ ____________ ______________________

______________________________ ____________ ______________________

List Major Medical Conditions of immediate family members (Mom, Dad, siblings, children) ____________

____

Primary Complaint (please list one main problem): ______________________________

Current Pain level 1-10 __________ How and when did this injury occur? What events led up to it (fall, overuse ect.)? ____

____

How does the chief complaint interfere with your life or what causes the pain (sleep disturbance, job performance, family relationships, emotional states, sports or hobbies, putting on clothing, bucking seatbelt, reaching for objects, stairs ect.? ______________________________

____

____

____

What have you tried to help the condition? (ice, heat, chiropractor, meds, injections, surgeries ect.)

____

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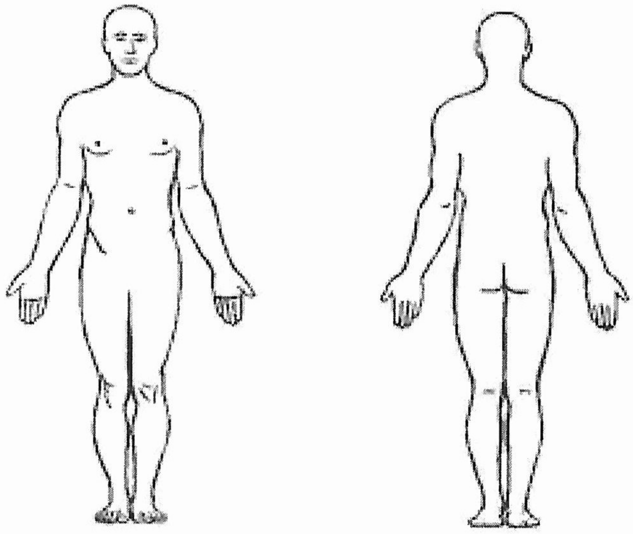
Did these things help?

____

Mark All areas of pain or discomfort



List each area marked above: How Long? Rate your pain 1-10

1st Complaint ____

2nd Complaint ____

3rd Complaint ____

4th Complain ____

REVIEW OF SYSTEMS (please circle) current or past problems:

Musculoskeletal – Joint pain, stiffness, joint swelling, difficulty moving or walking, dry mouth, sore eyes, back or neck pain, muscle pain, frequent falls, gout, muscle sprains, other ______________________________

____

Respiratory/cardiac: shortness of breath, cough, wheezing, night sweats, fever, skipping heart beats, blue fingers, toes, other ____

____

Neurologic: Seizures, tremor, involuntary movement, numbness, tingling, shooting pain, depression, other

____

GI: nausea, vomiting, constipation, diarrhea, acid reflux, other ______________________________

____

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Endocrine: Thyroid trouble, heat/cold intolerance, diabetes, other ______________________

____

Skin: Rashes, change in hair or nails, other ______________________

____

General: Arthritis, autoimmune disease, cancer, obesity, other ______________________

____

Current Medications, Prescription and/or Over-the-Counter: (you may bring a list or your medications)

- ________________________________
- ________________________________
- ________________________________
- ________________________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Feeling foggy	1 2 3 4 5	Diarrhea	1 2 3 4 5
Forgetfulness	1 2 3 4 5		

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Asthma	1 2 3 4 5	Arthritis	1 2 3 4 5	Chest Congestion	1 2 3 4 5
Muscle Aches	1 2 3 4 5	Sore throat	1 2 3 4 5	Neck Pain	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Joint Pain	1 2 3 4 5	Frequent Sneezing	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Chronic Cough	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Hay Fever	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Itchy/Watery Eyes	1 2 3 4 5

Solutions Integrated Medicine

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Elbow Pain	1 2 3 4 5	Hip Pain	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Itching	1 2 3 4 5	Shortness of Breath	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Knee Pain	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hoarseness	1 2 3 4 5	Wheezing	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________

Signature of the Patient, Parent or Guardian **Date**

______________________________ ______________

Signature of Doctor **Date**

We are really glad you came, you made the right decision.

*This is the place for you to "**regain your life!***

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Solutions Integrated Medicine, dba, John Samples, FNP-BC, Traci Cox, ANP, Fred Foshee, DO, James Warlick, DC, Dylan Levesque, DC, Molly Osibanjo, DC, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________, 20 ____.

X____________________________
(patient signature)

X______________________________
(signature of Guardian if applicable)

X______________________________
(please print patient name)

SOLUTIONS INTEGRATED MEDICINE
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other procedures, including various modes of physical therapeutic modalities and procedures, injections and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed providers who now or in the future work at the clinic or office listed above.

I will have an opportunity to discuss with the medical professionals listed below, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of medicine, and in the practice of chiropractic, there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains. Injections: It is understood to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The procedure may fail to reduce the pain symptoms

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the provider(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the provider(s) to exercise judgment during the course of the procedure which the provider(s) feels at the time, based upon the facts then known to him or her, is in my best interest. The providers named below can additionally explain the risks associated with my refusal of treatment, if that be the case.**Once services/supplies are rendered/delivered I understand there is no refunds for said services/supplies. In the event a refund is due to patient, it will be given to accountant and issued at end of month.**

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

<u>Solutions Integrated Medicine Providers:</u>

Fred Foshee, DO, James L Warlick, DC, Dylan Levesque, DC, Molly Osibanjo, DC,
John Samples, FNP-BC, Traci Cox, ANP

Patient/Guardian Signature________________________________ Date __________________

Witness Signature ______________________________________ Date ___________________

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:______________________________ DATE:____________________

For any YES answer, please notify the Doctor

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:______________________________
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:______________________________
3. Do your hands or arms fall asleep regularly? NO YES
   Comment:______________________________
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:______________________________
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:______________________________
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:______________________________
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ______________________________
8. Do your legs or feet fall asleep regularly? NO YES
   Comment:______________________________
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:______________________________
10. Do you suffer from cold hands or feet? NO YES
    Comment:______________________________
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:______________________________
12. Do you have difficulty maintaining your balance? NO YES
    Comment:______________________________
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment:______________________________
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment:______________________________
15. Do you suffer from ringing in your ears? NO YES
    Comment:______________________________
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment:______________________________

Solutions Integrated Medicine
Notice of Privacy Practices

By signing the form, you acknowledge receipt of the Notice of Privacy Practices from Solutions Integrated Medicine. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. We will have you review and sign the note of Privacy Practices annually or if the Notice of Privacy Practices has changed since your last visit. You may obtain a copy of Solutions Integrated Medicine Privacy Practices by requesting a copy from our office staff.

I acknowledge the receipt of the Notice of Privacy Practices from Solutions Integrated Medicine.

Signature:____________________________________ Date:_________________

(Patient or Legal Guardian)

Patient:______________________________________ Date:_________________

(Printed Name of Patient)

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.