HEALTH for LIFE
SPINE & DISC CENTER

New Patient Intake Form

Name _____ Age _____ Birthdate _____ Sex M or F
Home Address _____
City_____ State _____ Zip _____
Cell Phone _____ Email Address: _____
Who Referred You, Or How Did You Hear About Our Office? _____
Employer _____ Occupation_____ Length of Employ _____
Marital Status: S M W D Spouses Name _____

What is your highest level of education?	High School	Some College	2 Years College	4+ Years College
How often do you use caffeine?	Never	Occasionally	Often	
How much water do you drink daily?	More than 64oz	Less than 64oz		
How often do you consume alcohol?	Never	Occasionally	Often	
How often do you smoke?	More than 1 pack daily	Less than 1 pack daily	I don't smoke	
How often do you exercise?	Never	Occasionally	Often	
How much sleep do you get nightly?	8 hours or more	Less than 8 hours		
How often do you use recreational drugs?	Never	Occasionally	Often	

Please describe in **detail** the problem you're currently having, the very first time you recall having this problem and what it felt like?

_____

_____

Where is the pain located? Does it move around or stay in one location? _____

_____

Please **Circle** the pain as being… **Sharp** **Dull Ache** **Shooting** **Numb** **Stabbing** **Tingly** **Constant** **Comes and Goes**

How Serious Do You Think This Problem Is (circle one) … **MILD** **MODERATE** **SEVERE**
List any **Serious Medical Conditions** _____
List any **Broken Bones** _____
List any **Surgeries** _____
Pharmaceutical Drugs you are taking and for what condition: _____

_____

Previous **Accidents and Injuries**: _____

_____

List other **Treatments** you have tried: _____

Do you have any family members with significant medical conditions?

_____

What is your level of interest in **Non-Surgical Spinal Decompression** as a combined treatment option (if necessary)? Yes No Possibly

What is your level of interest in **RENU Aesthetic Treatment Plans** as a combined treatment option (if necessary)? Yes No Possibly

What do you think will happen to you if you cannot find a solution to your problem? _____

_____

Describe what will be different in your life if you can get better. _____

_____

What do you hope happens as a result of spending time with the doctor today?

_____

I (signature) _____certify that the information written above is both current and accurate to my personal knowledge and experience.

6033 Fashion Point, Suite 120
South Ogden, Utah 84403
Phone (801) 475-6800
Fax (801) 475-6802

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ASSIGNMENT OF BENEFITS
The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician and/or facility names above the following rights, power, and authority.

RELEASED INFORMATION: You are authorized to release and permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character as needed for treatment, payment, and health care operations.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms or my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician and/or facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician and/or facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

Signature _____ Date _____

FINANCIAL AGREEMENT AND CONSENT TO TREAT
1. Insurance is a method of reimbursement to the patient for fees paid to the doctor and is not considered a substitute for payment. We are willing to extend credit for a period of 45 days, allowing your insurance time to pay your claim. If your insurance has not paid within this amount of time, payment in full is expected from the patient or, in the case of a minor, the responsible party.
2. All co-pays, deductible, and co-insurance amounts are DUE AT THE TIME OF SERVICE.
3. It is the responsibility of the patient or, in the case of a minor, the responsible party, to obtain any and all referrals or authorizations required by your insurance.
4. Payment in full is expected at the time of service for all cash pay accounts. Treatment plan payments may be arranged with authorization from the doctor.
5. Services covered by a third party payer (Workers Compensation, Auto Insurance, etc.,) in legal action will be suspended from the patient's liability, with the exception of a lien patient payment made at the time of each service, as long as complete and correct information is given, including a signed lien.

I hereby consent to any medical treatment rendered to me or in the case of a minor, for whom I am legally responsible (hereafter known as "the minor"), the minor, and guarantee payment of charges incurred on my or the minor's behalf regardless of insurance coverage. I know that I am responsible for payment of this account.
I hereby assign and authorize payment of all medical (chiropractic and physical therapy) to which I or the minor are entitled for these services, including major medical benefits, Medicare, Worker's Compensation, Auto, Private Insurance and all other health plans to: Health for Life 6033 Fashion Point, Suite 120, South Ogden, Utah, 84403. A photocopy of this assignment is as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment of this account.

Signature _____ Date _____

ARBITRATION AGREEMENT
By signing this contract, you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract for more details.

Article 1. Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, this is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering is, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
A complete copy of the arbitration agreement is available upon request.

Signature _____ Date _____