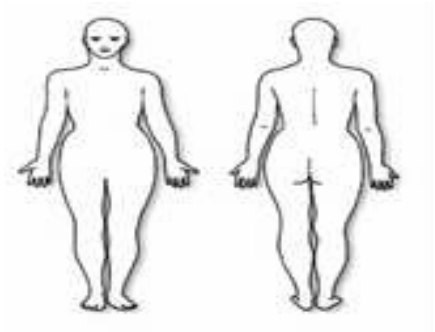
New Patient Registration

Dear Patient: please respond to the following questions as completely and accurately as possible. Your cooperation is greatly appreciated. This information will enable us to serve you better.

Patient Name: _____ Date:_____/_____/_____
Home Street Address: _____ Home Phone: _____
City:_____ State:_____ Zip Code: _____
Date of Birth: _____/_____/_____ Sex: F M Age: _____ Social Security #: _____- ____-_____
Cell Phone: _____ Email address: _____
Emergency Contact Person: _____ Phone#: _____
How Did You Hear About Us? _____
Please indicate if this condition resulted from and of the following:
Work Injury Motor Vehicle Accident Other Accident
Reason for Visit:_____
When did your current symptoms begin? (Month/day/year)_____
What makes your symptoms worse? _____ What makes your symptoms better?_____
Have you had any treatment for your current symptoms? _____

Please shade the areas where you have symptoms:



Rate your current pain on a scale from 0-10 by checking the box next to the number (0 = no pain; 10 = requires emergency care)

Current	Best	Worst
10	10	10
9	9	9
8	8	8
7	7	7
6	6	6
5	5	5
4	4	4
3	3	3
2	2	2
1	1	1
0	0	0

Indicate the words that most accurately describe your pain:

Shooting Throbbing Deep Aching Tingling Stabbing Sharp Numbness

Personal Medical History (check all that apply)

Osteoporosis	YES	NO
Cardiac	YES	NO
Cancer	YES	NO
Allergies	YES	NO
Pacemaker	YES	NO
COPD	YES	NO
High Blood Pressure	YES	NO
Diabetes	YES	NO
Arthritis (Rheumatoid/Osteo)	YES	NO
Psychological/Emotional Problems	YES	NO

Alcohol Use	YES	NO
Tobacco Use	YES	NO
Dizziness/Light Headiness	YES	NO
Double Vision	YES	NO
Difficulty Swallowing/Talking	YES	NO
Falls	YES	NO
Weakness	YES	NO
Fatigue	YES	NO

New Patient Registration

Terms of Payment Agreement

Payment for all services is due in full prior to services being rendered. Anatomy Optimized (AO) is not enrolled as a participating Medicare provider nor is classified as a non-participating Medicare provider. Our unique services blend various manual therapeutic techniques to facilitate physical rehabilitation and well-being combined with personal training and lifestyle guidance, and are not traditionally recognized by Medicare (and other third-party payors) as medically necessary. Thus, it is understood that the participating party is liable for any and all expense associated with services rendered by AO. In signing this form, you agree **not to** submit any AO invoice or documentation to your insurance company for reimbursement.

No refunds will be issued for any services rendered. We accept most forms of payments. Returned checks are subject to a $25.00 collection fee. **Missed appointments or appointments cancelled less than 24 hours in advance** are subject to a full treatment charge to mitigate for the loss of services that could have been provided to another patient during that time.

I _____, the undersigned, certify that I have read and agree to the "Terms of Payment", stated herein.

Patient Confidentiality/Protected Health Information (PHI)

AO is fully HIPAA compliant to ensure patient confidentiality. This policy enables us to develop a trusting therapeutic relationship between practitioner and patient.

I _____, the undersigned, grant AO permission to release information regarding my care to my personal physician and obtain medical records from my physician or other medical professionals as it relates to services provided by AO. I understand that AO will inform me prior to contacting any health care professional for information.

Consent for Treatment

I understand that I will receive education on my diagnosis, symptom pathology, exacerbating factors in addition to risks or alternatives to the treatment plan that has been prescribed by my practitioner. I also understand that my rehabilitation may require physical contact as the majority of my treatment is based on manual therapeutic approaches and can be sensitive in nature. Treatments could include Dry Needling and/or Spinal Manipulation. Verbal consent will also be received before performing these techniques. I understand that I have the right to refuse any treatment recommended by my practitioner and I agree to notify him/her if I feel uncomfortable in receiving or participating in any aspects of my care. I understand that I may experience post-care soreness and I agree to notify my practitioner should my symptoms last longer than 48 hours. By signing this agreement, I consent to have Orthopedic Spine Specialists Pain Therapy provide treatment and care as set forth and verbally discussed through my plan of care.

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

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