418 S. Keystone Ave.
Sayre, PA 18840
570-886-0385

RENEGADE PERFORMANCE

GENERAL INFORMATION (PLEASE PRINT CLEARLY)

Name:

DOB:

Sex:
☐ Male ☐ Female

Height:

Weight:

Phone/Cell:

Home:

Address:

City:

State:

Zip:

Email:

Referred by:

(Your email will NOT be shared with any 3rd parties and is only used for general office communication)

Emergency Contact:

Phone#:

Marital Status:
☐ S ☐ M ☐ D ☐ W ☐ DP

Drivers Lic #

SSN:

Name of Spouse/Parent:

Spouse/Parent Contact#

Chief Complaint(s):

CURRENT COMPLAINTS

Chief complaint(s):

Date of Injury:

Date Symptoms Began:

How did your pain begin?
☐ Immediately after a specific event ☐ After multiple events ☐ Gradually developed ☐ No apparent reason

Are your pain or symptoms:
☐ Improving ☐ Worsening ☐ Not changing

Are your pain or symptoms:
☐ Constant (75-100% of time) ☐ Frequent (51-75%) ☐ Occasional (25-50%) ☐ Intermittent (25% or less)

Have you ever had a similar problem before? ☐ Yes ☐ No If so, When:

Does anything decrease your pain or symptoms?

What makes your pain worse?

Is this interfering with your
☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports ☐ Recreation ☐ Other? If so, please explain:

What is the functional goal you would like to achieve? *(i.e. return to sport/recreation, regain personal independence, become stronger, play with kids again etc.)*

CURRENT COMPLAINTS *Continue....*

Have you been treated for any of these conditions in the past year? ☐ Yes ☐ No If YES, please check:

☐ Surgery ☐ Injections ☐ Physical Therapy ☐ Supportive devices

☐ Medications _____ ☐ Other _____

Did they help? ☐ Yes ☐ No

Prior tests, results and dates: (X-ray, MRI, CT, ultrasound, lab, other):

Have you ever been treated by a chiropractor before: ☐ Yes ☐ No If yes, please provide:

Date of last visit: Name of previous chiropractor:

How would you rate your general stress levels?

☐ None ☐ Minimal ☐ Moderate ☐ Great

Are your complaints affecting your ability to work or otherwise be active?

☐ Some restrictions (able to perform light duty work & household tasks) ☐ No effect

☐ Need limited assistance with common everyday tasks ☐ Need assistance often

☐ Significant inability to function without assistance ☐ I am totally disabled (impaired and cannot care for self)

How much time do you spend? (please check)

Sitting	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
Standing	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
Computer work	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
Strenuous manual labor	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
Moderate manual labor	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
On the Phone	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None
Driving	☐ Most of the day	☐ Half of the day	☐ A little of the day	☐ None

Please List each area of your symptoms in order of severity. Then at the scale below, mark (X) at a point along the that demonstrates the level of severity.

Areas of Symptom	No Pain or Symptoms				**Severity**						Worst Pain Imaginable
1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10
4.	0	1	2	3	4	5	6	7	8	9	10

In the area to the right please indicate where you are experiencing pain or symptoms by drawing in the letter abbreviations on the diagrams

Sharp Pain = P

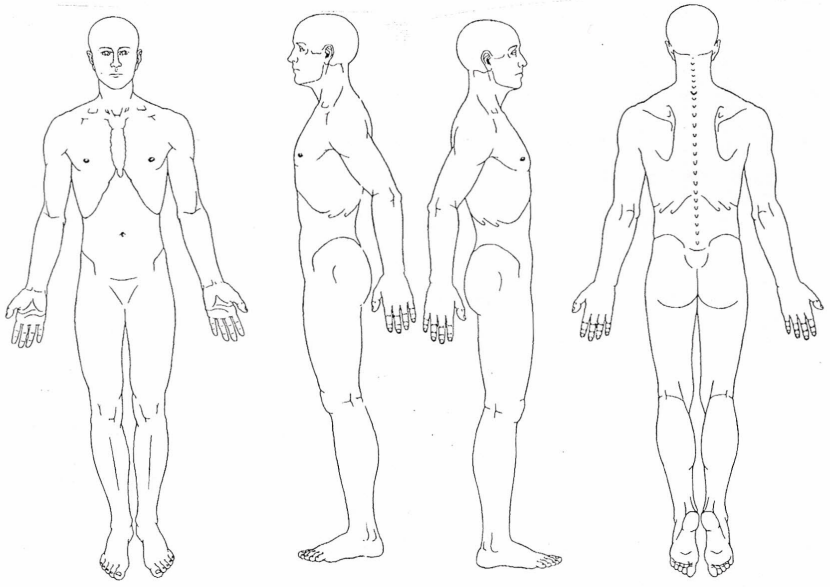
Stiffness = S

Tingling = T

Dull Pain = D

Numbness = N

Burning = B



MEDICAL HISTORY

Have you been treated for any other conditions in the last year? ☐ Yes ☐ No If yes, please describe :

Date of Last physical exam: Findings?

Have you had any dental care or minor surgery in the last 4 weeks?	☐ Yes ☐ No
Are you, or do you think that you may be pregnant?	☐ Yes ☐ No If yes, # of weeks:
Do you ever experience night sweats?	☐ Yes ☐ No
Do you experience night pain that keeps you from sleeping?	☐ Yes ☐ No
Have you had any unexpected weight loss?	☐ Yes ☐ No
Do you experience any numbness?	☐ Yes ☐ No
Do you experience any tingling?	☐ Yes ☐ No
Do you experience any muscle weakness?	☐ Yes ☐ No

Please List Any:	Date:	Please Describe:
Motor Vehicle Accident		
Recent Work Injury		
Sports/Recreational Injury		
Falls or Other Traumas		
Surgeries		
Hospitalizations		
Other Medical Conditions		

Medication/Supplement	Dosage	Reason for taking	Takin since (date)

FAMILY HEATH HISTORY

Family Members	Medical Conditions: Past and Present (IE: Heart Disease, Cancer, Diabetes, Thyroid Problems, Mental Health Disorders, Genetic Disorders ect.)
Mother	
Father	
Sister	
Brother	

GENERAL INFORMATION

General Habits	None	Light	Moderate	Heavy
Coffee/Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐

Do you have any difficulty with the following?

- Please place "**N**" in the space if the condition is Now
- Please place "**P**" if the condition was in the Past

Abdominal Pain	Gout	Nervousness
Alcoholism	Gynecological Problems	Pneumonia
Allergy	Hardening of Arteries	Poor Appetite
Anemia	Hearing Problems	Prostate Problems
Arthritis	Heart Disease	Sciatica
Asthma	Headaches	Short of Breath
Cancer	Hemorrhoids	Sinus Trouble
Chest Pain	Hepatitis	Sleeplessness
Colds/Infections	High Blood Pressure	Stress
Colon Trouble	HIV / AIDS	Stroke
Constipation	Indigestion	Thyroid Trouble
Depression	Kidney Trouble	Ulcers
Diabetes	Knocked Unconscious	Varicose Veins
Dizziness	Liver Trouble	Vision Problems
Epilepsy	Lung Problems	Weight Gain
Fatigue	Mental Disorders	
Gall Bladder	Nausea	

SIGNATURE

Patient's Signature	Guardian's Signature
Date	Date

NOTICE OF PRIVACY PRACTICES

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.

Renegade Performance, LLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Workers' Compensation

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing and Other Communications

We may contact you for marketing purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on you answering machine or with the

person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.

Change of Ownership

In the event that Renegade Performance, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Renegade Performance, LLC is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Renegade Performance, LLC amend your protected health information. Please be advised, however, that Renegade Performance, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Renegade Performance, LLC.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Renegade Performance, LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Renegade Performance, LLC is required by law to comply with this Notice.

Renegade Performance, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Renegade Performance, LLC by calling this office at (570)-886-0385. If Renegade Performance, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your privacy rights, or how Renegade Performance, LLC has handled your health information should be directed to Renegade Performance, LLC by calling this office at (570)-886-0385. If Renegade Performance, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my right contained in the notice.

By way of my signature, I provide Renegade Performance, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's name (print)

Patient or Legal Guardian Signature **Date**

Informed Consent for Chiropractic Treatment and Care

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy (or on the patient named below, for whom I am legally responsible for) by the doctor or intern, affiliated with Renegade Performance, LLC.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise proper judgment during the course of the procedure(s) by which the doctor feels at that time, based on the facts then known, are in my best interest.

I have read, or have had this read to me, the above consent. By signing below, I agree to the above and allow the doctor or intern, affiliated with Renegade Performance, LLC to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (PRINTED) **Date**

_____ _____

Patient's Signature **Guardian's Signature**

PAYMENT POLICY

Thank you for choosing Renegade Performance as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE**. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.

2. **CO-PAYMENT AND DEDUCTIBLES.** *All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.*

3. **PROOF OF INSURANCE.** *All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.*

4. **CLAIM SUBMISSION.** *We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.*

5. **COVERAGE CHANGES.** *If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.*

6. **MISSED APPOINTMENT.** *Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you.* ***Please help us to serve you better by keeping your regular scheduled appointment****.*

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party ***Date***