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Hope Miller, DC, DACBSP
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James Remien, LMT

62 Lake Avenue So, Suite C
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631-584-TRUE (8783)
Fax 631-584-8784
truesportcare.com

TRUE SPORT CARE

STRENGTHEN AND PROTECT SEASON AFTER SEASON

INFORMATION

Patient_____

Street Address_____

City_____

State_____Zip Code_____

Email_____

Who may we thank for referring you?_____

Sex: ____ M ____F Age_____ Birthdate_____

Patient SS#_____

Home Phone_____

Cell Phone_____

Best time and number to reach you _____

In case of emergency, please contact _____

Relationship _____

Home:_____Cell_____

INSURANCE INFO

Accident _____Y _____N Work injury _____Y _____N

Insurance Co_____

ID#_____

Phone_____

****THE FOLLOWING INFORMATION MUST BE FILLED OUT****

INSURED'S NAME_____

INSURED'S STREET ADDRESS:

_____

CITY_____

STATE_____**ZIP CODE**_____

RELATIONSHIP TO INSURED:_____

INSURED'S DATE OF BIRTH:_____

INSURED'S PHONE_____

How will you be paying for today's visit?_____

PATIENT CONDITION

Reason for visit _____

On the picture to the right, mark an "X" on the location(s) of your pain:

When did your symptoms begin? _____

Did the condition begin suddenly or over time?_____

Is the condition getting worse, better or is not changing?_____

Rate the severity of your pain on a scale from 1(Least pain) to 10(Worst pain)_____

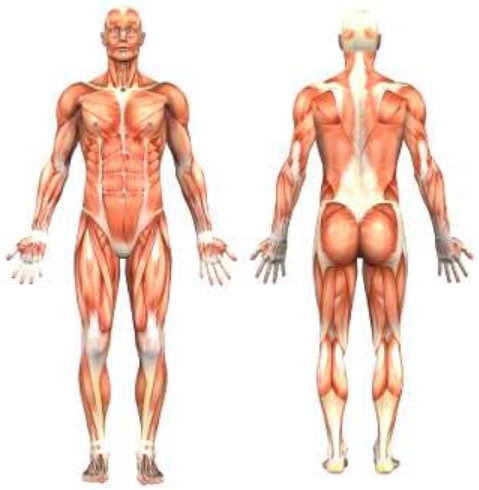
Do you have pain ____Constantly ____Off and on ____Occasionally

What actions can you perform to make the pain worse?_____

What actions can you perform to make the pain better?_____

What other treatments have you tried for this condition?_____

Any previous medical history which may be clinically important, ie. fractures, osteopenia/osteoporosis, surgeries, diabetes,etc. Please include all: _____



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ATTENTION PATIENTS: PLEASE READ AND SIGN EACH SECTION

APPOINTMENT POLICY

It is the policy of most Doctors offices to double and triple book their appointments because of potential cancellations and no-shows. The problem with this policy is that if all the scheduled patients show, there will be a substantial back up in the office. We feel your time is as important as our time therefore we feel this scheduling practice is unfair. This is why WE DO NOT OVERBOOK and why we ask for your cooperation in keeping your appointments or giving us as much notice as possible when canceling. **There is a $40 charge for missed appointments.**

PATIENT SIGNATURE:_____DATE:_____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctors of True Sport Care or other licensed doctors of chiropractic who now or in the future work at True Sport Care. I have had an opportunity to discuss with the doctor or clinic personnel the nature and purpose of chiropractic treatments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
I have read the above consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

PATIENT SIGNATURE:_____DATE:_____

PARENT SIGNATURE:_____DATE:_____

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LEGAL-FINANCIAL RESPONSIBILITIES

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to True Sport Care for any charges not covered by health care benefits. It is my responsibility to notify True Sport Care of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by True Sport Care and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to True Sport Care for all covered medical services and supplies provided to me during all courses of treatment and care provided by True Sport Care and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by True Sport Care, and will constitute a continuing authorization, maintained on file with True Sport Care, which will authorize and allow for direct payment to True Sport Care of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by True Sport Care.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other medical entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by True Sport Care. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by the True Sport Care.

PATIENT SIGNATURE:_____DATE:_____