TRAIN AWAY PAIN

NO PAIN. NO GAIN. NO MORE.

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Westport, CT 06880
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PATIENT INFORMATION FORM

First Name:____________________ Middle Initial: ____ Last Name: ________________________________

Address: ____________________________________ City: ________________ State:____ Zip Code: __________

Home Phone: ___________________ Work Phone ____________________ Cell Phone ____________________

Email address: ___________________________ Date of Birth:_______________

Sex: Male Female Marital Status: Single Married Other __________

REFERRED BY: ________________________________

EMERGENCY INFORMATION:

Emergency Contact: _________________________________ Relationship: ____________________

Emergency Contact Number(s): (H/W/C) (circle) ____________________ (H/W/C) (circle) ____________________

Emergency Contact Email: _____________________________

**INFORMED CONSENT WAIVER AND AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature, that I am aware that the TAP practitioner is a licensed chiropractic physician or physical therapist and although rare, injury from treatment or manipulation may have affects that may include stroke, disc herniation and/or other injuries or complications.

Signature ___________________________________Date______________

Signature of Parent or Guardian if patient is under 18: _____________________________________Date:_____

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION RELATED TO PATIENT:

I the undersigned, authorize the release of medical information to the EMERGENCY CONTACT named on this form:

Signature ____ Date_________________________________

Signature of Parent or Guardian if patient is under 18: ________________________________Date______

Appointment cancellations require 24-hour notice to avoid visit charge.

INSURANCE INFORMATION

Train Away Pain is an out-of-network facility for all insurance providers with the exception of Anthem Blue Cross Blue Shield for Zack White and Michael Fortin.

With your permission, we will contact your insurance company and confirm the details of your benefits for out-of- network providers. This includes co-insurance amounts, deductible requirements, coverage exclusions, coverage limitations and categories of patient care that are covered. We will inform you of the information that we obtain.

Insurance Company ______________________

ID/Policy Number _______________________

Do you have a Medical Flexible Spending Account? Yes No

Important: If you are not the policyholder, please provide the following policyholder information. PSM will need this in order to process insurance claims.

Insured's Name _________________________ Insured's date of birth ___________________

Insured's Home Address (If different from patient): ____

Insured's Telephone: (W/H/C) _________________ Insured's Email: ______________________________

(circle)

Your relationship to the Policyholder: Self Spouse Child Other ____

AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

____ ________________________

Signature of patient or person acting on patient's behalf Date

Please provide us with your insurance card. We will make a copy for our records.

Train Away Pain Financial Policy

The well-being of our patients is our primary concern and our goal is to provide excellent care to everyone who seeks our services. Part of maintaining a good physician-patient relationship is advising you in advance of office policies related to our practice. Please read this page carefully and indicate your agreement by signing below. If you have any questions, please do not hesitate to ask a member of our staff.

1. It is your responsibility to notify the office of any changes to your address and/or new insurance coverage.
2. Payment for services is due upon completion of the visit. We require that all patients maintain a VALID credit card. If we are unable to bill you at the time of service, the cost of your visit will be automatically billed on your credit card.
4. While we may verify your insurance coverage as a courtesy, it is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. Payment for all TAP services is the responsibility of the patient and is due at the time of your visit. As out-of-network medical providers, TAP does not participate in any private or government sponsored insurance plans. We will, however, submit insurance claims for services provided to commercial insurance companies on our patients' behalf.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. If for any reason there are unpaid account balances that are more than thirty (30) days past due, such balances shall accrue interest at the rate of eighteen (18%) percent per year on any and all past due amount. In the event that your account is sent out for collection, you will be liable for all reasonable attorney fees and expenses.
8. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
9. All packages purchased are non-refundable and must be used within one year of the purchase date.
10. We require a 24-hour notice for cancelling any appointments. We reserve the right to assess a $50 charge for missed appointments.
11. A $35 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name: ______________________________

____ ______________________

Name of Responsible Party Relationship

____ ______________________

Signature of patient, or person signing on the patient's behalf Date

This signature will serve as credit card authorization signature for any remaining balances.

Are you currently experiencing or have you ever been diagnosed with any of the following?
Please check Y or N then initial at the bottom of the page.

CARDIOVASCULAR	Y	N	GASTROINTESTINAL	Y	N	NEUROLOGICAL	Y	N
Aneurysms			Abdominal Pain			Dizziness		
Bypass Surgery			Difficulty Swallowing			Numbness/Tingling Arms/Legs		
Chest Pain			Heartburn			Involuntary movement		
Deep Vein Thrombosis			Hernia Nausea			Migraines		
Heart Palpitation			Stomach Cancer			Paralysis		
Heart Murmur						Seizures		
High Cholesterol			**GENITOURINARY**			Vertigo		
History of Heart Disease			Frequent Urination					
Pacemaker			Kidney Infections			**CONSTITUTION**		
Pain in Legs After Walking			Ovarian Cancer			Appetite Changes		
Raynaud's Syndrome			Prostate Cancer			Fatigue		
Shortness of Breath			Urinary Tract Infection			Insomnia		
Stent						Light Headedness		
Stroke			**MUSCULOSKELETAL**			Loss of Sensation		
Swelling in Hands /feet			Arthritis			Night Sweats		
Syncope			Bone Cancer			Weight - Sudden Loss		
High Blood Pressure			Gout			Weight - Sudden Gain		
			Joint Pain					
EARS,NOSE & THROAT			Joint Tumor			**ENDOCRINE**		
Chronic colds			Limited Range of Motion			Diabetes Type I		
Chronic Strep Infections			Multiple Myeloma			Diabetes Type II		
Dentures			Multiple Sclerosis			Hyperthyroidism		
Dizziness			Muscle Cramps			Hypothyroidism		
Ear Pain			Osteoporosis					
Nose Bleeds			Scoliosis			**GENERAL**		
Sinusitis			Muscle Weakness			Drink alcohol		
TMJ			Muscle Tenderness			#/Week		
Vertigo						Smoke		
			INTEGUMENTARY			#/Day		
RESPIRATORY			Bruising					
Asthma			Changes in Nails/Hair					
Dyspnea			Psoriasis					
Emphysema			Skin Cancer					
Lung Cancer			Skin Rash					
Tuberculosis								
Wheezing								

PAIN

Please mark on the diagram the type of pain and location you are currently experiencing.
Place the appropriate symbol or letter on the diagram:

A: Ache N: NumbnessPins & Needles: O Burning: X Stabbing: /

Please answer the questions below

Is this the first time for this type of pain? Y or N
If not, when was the first episode? ___________________________________
How did this episode occur?____
How did the first episode occur (if applicable)?
____
Have you have previous experience with a Chiropractor?____

Onset date of injury	
Timing? (ex: morning)	
Location? (ex: lower back)	
Quality? (ex: aching)	
Context? (ex: sitting)	
Severity? (ex: moderate)	
Duration? (ex: 30 minutes after waking)	
Signs/Symptoms?	
Relieving Factors? (ex: rest)	
Aggravating factors? (ex: lifting)	
Please list past treatments	
Please rate your pain today (on a scale of 1 to 10, 10 being the worst)	
Please rate the worst the pain has been (scale 1 to 10)	
Please rate the best it has been (scale 1 to 10)	

Please list any significant medical illnesses /diagnoses given to you by a physician.
Please list any previous surgeries or hospitalizations, the date and the reason.
Please list any medications you are currently taking, dosage and frequency.