Apple Physical Medicine and Rehabilitation
7446 Shallowford Road Suite 108 Chattanooga TN, 37421
Phone (423) 855-7376 Fax (423) 855-8455
Email info@applerehabgroup.com **Website applerehabgroup.com**

*Please **PRINT** in pen legibly and fill out completely*

Name: _____ Date:_____
Address: _____ City:_____ State:_____ ZIP:_____
Email Address: _____ Social Security Number:_____
Birth Date: _____ Driver's License Number:_____ License State:_____
Preferred Language: ☐ English ☐ Spanish **Race:** ☐ White ☐ Hispanic ☐ Non- Hispanic ☐ African American ☐ Native American ☐ Other _____
Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Living Alone** ☐ **Living with Others**
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Employer:_____Occupation:_____
Emergency Contact: _____ Relation:_____ Phone:_____
Family Physician: _____ Phone:_____
How did you hear about our office: ☐ **Friend** ☐ **Radio** ☐ **TV** ☐ **Internet** ☐ **Insurance Company**
If referred by physician please provide name: _____

Please allow us to make a copy of your insurance card/s and License.

AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS.
I hereby authorize APMR to administer such treatments and release information regarding treatment or examination rendered to me for medical care to insurance company(s) or its representatives. I also authorize payment to be made directly to APMR in the amount due for all provided services for my eligible dependents or myself. I understand that I am financially responsible for any amounts not covered or paid by my insurance company. **Furthermore, I authorize APMR to obtain my medical records from any necessary doctor's office hospital, or clinic.**
Name: _____ Date: _____

Signature of Patient or Guardian: _____Date: _____

Patient Questionnaire:

How and when did your symptom(s) start: _____
Did your symptom(s) result from an accident: ☐ **Yes** ☐ **No If yes Detail:**
_____

Primary Complaint: ☐ **Neck** ☐ **Mid Back** ☐ **Low Back** ☐ **Shoulder** ☐ **Hip** ☐ **Knee** ☐ **Elbow** ☐ **Hand** ☐ **Foot (Rt** ☐ **Lt** ☐**)**
Secondary Complaint: Neck ☐ **Mid Back** ☐ **Low Back** ☐ **Shoulder** ☐ **Hip** ☐ **Knee** ☐ **Elbow** ☐ **Hand** ☐ **Foot. (Rt** ☐ **Lt** ☐**)**

1) Please rate your pain on a scale from 1-10 (10 being the most painful)
At its worst: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**
At rest: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

2) Is the pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant
3) Is the pain: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Numb
4) What makes the symptoms better: ☐ Nothing ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Chiropractic ☐ Physical Therapy ☐ Stretching ☐ Exercise ☐ Medication
5) What makes the symptoms worse: ☐ Nothing ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Chiropractic ☐ Physical Therapy ☐ Stretching ☐ Exercise ☐ Medication
6) What treatment have you tried: ☐ Medication ☐ Rest ☐ Chiropractic ☐ Physical Therapy ☐ Exercise ☐ Heat/Ice ☐ Surgery ☐ Epidural injections (ESI) ☐ Radio Frequency Ablation (RFA)

Staff Initials: _____

Name: _____ ***Date:*** _____

***7) Have you had any of the following test/studies*:**

☐ X-rays ☐ MRI ☐ CAT SCAN ☐ NCV/EMG ***What Facility were tests performed:*** _____

8) Social History:

Tobacco Use: ☐ Yes ☐ NO
Frequency: ☐ Occasional ☐ Frequent

Alcohol Use: ☐Yes ☐ NO
Occasional ☐ Frequent

Caffeine Use: ☐ Yes ☐ NO
Occasional ☐ Frequent

Exercise Regularly: ☐ Yes ☐ NO
Frequency: ☐ Occasional ☐ Frequent

9) Family History:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease
☐ Stroke ☐ Osteoporosis ☐ Arthritis ☐ Cancer

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease Frequency: ☐
☐ Stroke ☐ Osteoporosis ☐ Arthritis ☐ Cancer

Maternal Grandparents: ☐Diabetes ☐ Hypertension Frequency: ☐
☐Heart Disease ☐ Stroke ☐ Osteoporosis ☐ Arthritis ☐ Cancer

Paternal Grandparents: ☐Diabetes ☐ Hypertension
☐ Heart Disease ☐ Stroke ☐ Osteoporosis ☐ Arthritis ☐Cancer

10) Review of Symptoms

Musculoskeletal: ☐ Neck Pain ☐ Joint Pain ☐ Joint Stiffness ☐ Swelling in Joints ☐ Jaw Pain ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Osteoporosis
Neurological: ☐ Headaches ☐ Seizures ☐ Numbness ☐ Tingling ☐ Tremors ☐ Stroke ☐ Dizziness ☐ Fainting
EENT: ☐ Glaucoma ☐ Cataracts ☐ Glasses/contacts ☐ Earache ☐ Hearing loss ☐ Nasal Discharge ☐ Nasal Congestion ☐ Nose Bleeds ☐ Sinus Pain/Pressure
Endocrine: ☐Excessive weight gain/loss ☐ Excessive Thirst/Hunger ☐ Excessive urination ☐ Hot/cold Intolerance ☐ Diabetes ☐ Thyroid Disease ☐ Hepatitis
Respiratory: ☐ Asthma ☐ Shortness of Breathe ☐ Cough ☐ Wheezing ☐ Tuberculosis
Vascular/Cardiovascular: ☐ Anemia ☐ Chest Pain ☐ Palpitation ☐ Heart Disease ☐ Hypertension ☐ High Cholesterol ☐ Peripheral Artery Disease (PAD)
Gastrointestinal: ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Heartburn ☐ Change in Appetite ☐ Nausea/Vomiting ☐ Gastritis/Ulcer Disease ☐ GERD (Acid Reflux)
Genitourinary: ☐ Trouble Urinating ☐ Pain with Urination ☐ Blood in Urine ☐ STD ☐ HIV/AIDS

11) Medication/ Supplements ☐ **None** ***Please List or Provide a List:***

_____

12) Past Surgical History: ☐ **None** ***Please List or Provide a List of any Surgeries:***

_____

13) Allergies to the following: ☐ Birds ☐ Feathers ☐ Eggs ☐Sulfur ☐ Products containing shellfish ☐ Products containing iodine ***Please List or Provide a List of any other allergies:*** _____

_____

HIPPA

RELEASE OF PERSONAL INFORMATION TO NON-MEDICIAL PERSONS

☐ ***I Do Not* Allow** any individuals to have access to the following information Contained in my records
☐ ***I Do Allow*** the individuals listed below to have access to the following information Contained in my records
(Check all that apply): ☐ **MEDICAL** ☐ **FINANCIAL** ☐ **BOTH**
You may revoke this authorization in writing at any time.

Name: _____ Relationship to the Patient: _____

Name: _____Relationship to the Patient: _____

Know your Rights Please review our HIPPA policies. Our HIPPA policies are available posted in our office, on our web site if you would like a copy please feel free to ask a staff member. By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____Date: _____

Print Name: _____Date: _____

Staff Initials: _____

Name:_____ **Date:**_____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ___ /___ /___

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Apple Physical Medicine and Rehabilitation in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Apple Physical Medicine and Rehabilitation until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative Date

Relationship to Patient: _____ Driver's License Number: _____State____

Limited Prescribing Agreement

We would like all of our patient to understand that we will not under any circumstances be prescribing narcotic pain medication. Because of the high occurrence for addiction/ tolerance, we choose not to engage in this type of prescribing. We will however attempt to find non-narcotic ways to relieve any pain that you may be experiencing. We appreciate your cooperation with this agreement by not asking or expecting to receive any type of narcotic pain medication. Please sign below stating that you understand and will cooperate with this agreement.

Sign: _____ Date: _____

Staff Signature: _____

Staff Initials: _____

Insurance Policy
Please Read Carefully and Sign

***The verification this office gets from your insurance carrier does not guarantee payment of services; *your* insurance company will make the final decision once they receive a claim from our office in their offices. If you disagree with the benefits, they have given our office, it is *your* responsibility to contact your insurance company to settle the dispute.**

1. It is the policy of this office to extend as a courtesy to our patients the service of filing your insurance, with assignment of benefits paid directly to us. This policy allows you and your family to receive treatment while reducing your out of pocket expense.
2. The **privilege** of insurance assignment begins when your insurance forms/card(s) are received and verified by our office.
3. All deductible payments **MUST** be made.
4. Our office will verify your insurance coverage in an effort to help you determine exactly what treatment coverage is available to you under your policy.
5. All payments/co-payments are payable when services are rendered. (Co-payment is that part of our service that is not paid by your insurance.)
6. We **do not own your policy**, so from time to time we may experience difficulty in collecting our fees from your insurance company. In the event this does occur we will give you ample notice and ask that you act on your own behalf with your insurance company to help correct the problem or problems.
7. This office does not promise that any insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement. Accounts become delinquent after **90** days. **Following 120 days the account will automatically be turned over to collections unless prior payment arrangements have been made. Browns Agency handles the collections and will charge a 33% fee to all accounts sent to collections.** You can make payments on your accounts directly to our office at 7446 Shallowford Road Suite 108, Chattanooga, TN 37421. When making a health care decision, it is important to remember that you, the patient, are ultimately financially responsible for any services rendered and that payments toward any balance not covered by insurance should be paid in full.
8. From time to time, supplies, such as orthotics, TENS units, or electrodes may be required in order to help in your treatment. In most cases, your insurance **will not** cover these extra expenses. You will be responsible for these expenses.
9. Lastly, it is the goal of this office to provide you with the finest quality of care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

ALL PATIENTS
NOTICE OF ASSIGNMENT
Your insurance is instructed to pay directly to our office and billing company for all professional services rendered by this office. This instruction to you is an assignment of my rights under medical coverage to the extent of the bill. THIS INCLUDES ALL CLAIMS, BE THEY 1ST OR 3RD PARTY CLAIMS.
I acknowledge my responsibility and agree to pay in full for the professional services rendered. I understand that this office may bill my health insurance for the services rendered, but such billing does not relieve me of my responsibility to pay for services. I am also responsible for my deductible and co-pay, if any. Should my account become delinquent and collection procedures become necessary, I understand that **I will be responsible for collection fees of 33%, that will be added to the unpaid balance. If my account is sent to an attorney, I will also be responsible for their fees as well as any court costs.**
Patient Name: _____
Patient/ Guardian _____
MEDICARE PATIENT ONLY
MEDICARE PATIENT ACKNOWLEDGEMENT AND UNDERSTANDING
This is to certify that I have been informed that this office is a participation Medicare provider. This does not guarantee that Medicare will pay for all services deemed necessary by the doctor (**Medicare only covers manipulation for chiropractors).** I authorize this office to file my Medicare claims for me, and I agree to pay for all services **not** covered by Medicare. If **Treatment** is not covered for any reason you will be required to sign an **Advance Beneficiary Notice (ABN).**
Print Name_____
Sign: _____ Date: _____
I have read and reviewed the information herein and represent that the same is true, correct, and complete. I understand that the doctor is relying upon information given by me in rendering my treatment.

Staff Initials: _____