



Patient Information

Last Name: _____ First Name: _____ MI _____

Mailing Address: _____ City/State/Zip: _____

Primary Phone: (____) _____ - _____ Alternate Phone: (____) _____ - _____

Email: _____ @ _____ Date of Birth ____ / ____ / ____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about iMed Centers? _____

Responsible Party Information (Parent Information if Patient is a Minor)

Name: _____

Address: _____ City/State/Zip: _____

Primary Phone: (____) _____ - _____ Alternate Phone: (____) _____ - _____

Insurance Information

Primary Insurance Company Name: ___ Anthem ___ Cigna ___ Aetna ___ Other: _____

Patient Relationship to Insurance Subscriber: ___ Self ___ Spouse ___ Child ___ Other: _____

Name of Subscriber: _____ Date of Birth ____ / ____ / ____

Insurance ID #: _____ Group #: _____ Effective Date: _____

Emergency Contact Information

Name: _____ Relationship: _____

Primary Phone: (____) _____ - _____ Alternate Phone: (____) _____ - _____

Name: _____ Age: _____ Date: ____/____/____

HEALTH HISTORY

What is your overall goal(s) in coming to Norwalk iMed Center? Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Posture Correction | <input type="checkbox"/> Balance Training |
| <input type="checkbox"/> Ergonomic Training | <input type="checkbox"/> Strengthening | <input type="checkbox"/> Wellness |
| <input type="checkbox"/> Post Surgical Rehab | <input type="checkbox"/> Pre Surgical Training | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Other (please specify): _____ | | |

Medical History

Do you have any of the following symptoms?

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headaches
- Loss of Sleep
- Loss of Weight
- Nervousness
- Numbness
- Sweats

Muscle/Joint/Bone

Pain, Weakness, numbness in:

- | | |
|--------------------------------|------------------------------------|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Back | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders |

Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Men Only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other: _____

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heartbeat
- Low blood pressure
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins

Women Only

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-flashes
- Vision-halos

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

- Painful intercourse
- Vaginal discharge
- Other: _____

DO YOU HAVE any other medical conditions?

Past Surgeries/Hospitalizations?

1) _____ Estimated date: _____ 3) _____ Estimated date: _____
2) _____ Estimated date: _____ 4) _____ Estimated date: _____

Current list of medicines (medications, vitamins, herbs, and/or supplements with dosages and frequencies):

1) _____ Dosage: _____ Frequency: _____
2) _____ Dosage: _____ Frequency: _____
3) _____ Dosage: _____ Frequency: _____
4) _____ Dosage: _____ Frequency: _____
5) _____ Dosage: _____ Frequency: _____

Allergies:

Preferred Pharmacy for Electronic Prescriptions (e-Rx):

Pharmacy: ___ CVS ___ Walgreens ___ Stop & Shop ___ Walmart ___ Other: _____

Address: _____ City/State _____

Family History:

___ Heart disease ___ Asthma
___ Cancer ___ Kidney disease
___ Kidney disease ___ High blood pressure
___ Stroke ___ History of alcohol / drug addiction
___ Diabetes ___ Hay fever
___ Arthritis ___ Gout
___ Tuberculosis ___ Other: _____

Social History:

Marital Status: _____
Smoke: Y / N Frequency: _____
Exercise: Y / N Frequency: _____
Employer: _____

Women: Are you or might you be pregnant? Y N Number of Pregnancies: _____ Live Births: _____

Living Children/ gender/ ages: 1) M / F _____ 2) M / F _____ 3) M / F _____ 4) M / F _____ 5) M / F _____

Complications during pregnancy or delivery? _____

Name: _____ Age: _____ Date: ____/____/____

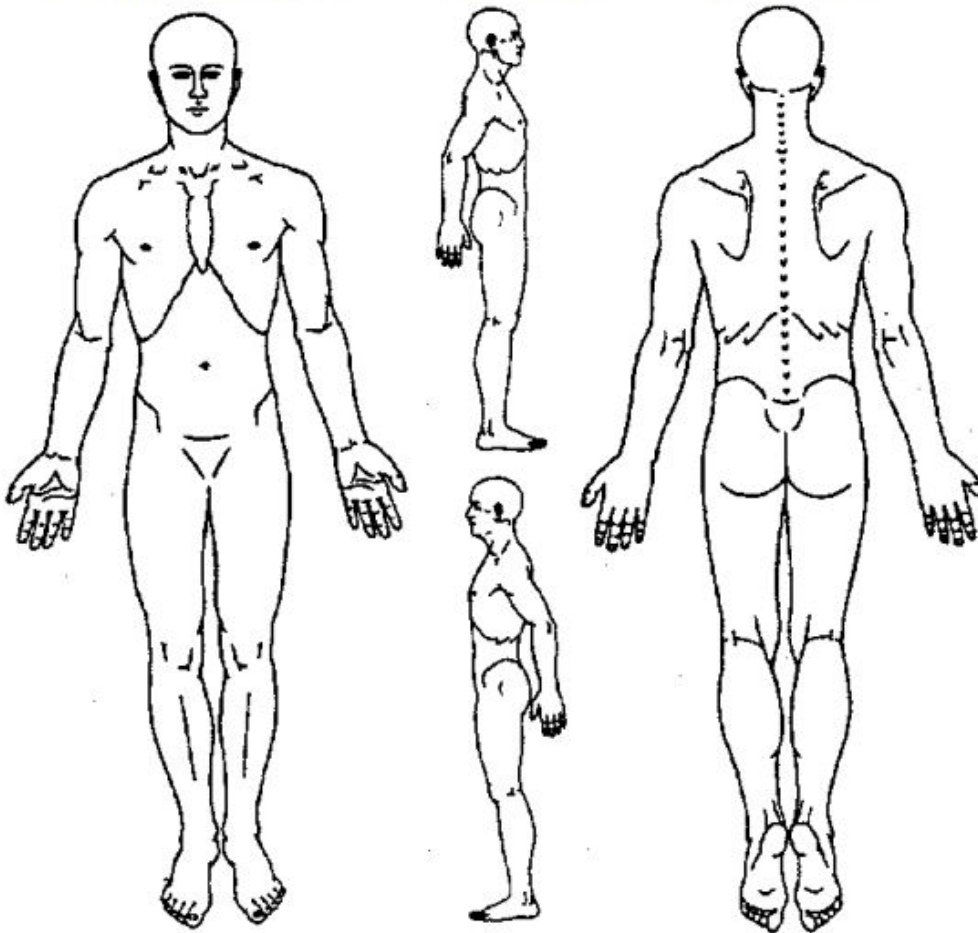
Please review the list below:

| <i>Previous Treatment</i> | <i>Have used in the past</i> | <i>Worked well for me</i> | <i>Would like to try</i> |
|---------------------------|------------------------------|---------------------------|--------------------------|
| Chiropractic | _____ | _____ | _____ |
| Physical Therapy | _____ | _____ | _____ |
| Massage | _____ | _____ | _____ |
| Acupuncture | _____ | _____ | _____ |

PAIN DIAGRAM

On the diagram below, mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** - ACHE **B** - BURNING **N** - NUMBNESS
P - PINS & NEEDLES **S** - STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

| | | | | | | | | | | |
|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|---------------------|
| No Pain | | | | | | | | | | Worst Possible Pain |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

CONSENT FOR TREATMENT

I have been informed of the nature of my disorder(s) and of the nature and purpose of physical therapy, chiropractic care, massage therapy and physical medicine as treatment. I have also been informed of the possible consequences and risks inherent in such treatments. The availability of these treatment options have been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand there is no guarantee or warranty for any specific cure or result.

Consent for the following treatments:

- Physical Medicine
- Chiropractic Care
- Physical Therapy
- Massage Therapy

I HAVE READ THE ABOVE PARAGRAPH AND I UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature: _____ Date: ____/____/____

HIPAA PRIVACY STATEMENT

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and give patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

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.

This Notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding such medical information. We are required by law to make sure that medical information which identifies is kept private; give you this Notice of our legal duties and privacy practices with respect to your information; and follow the terms of the Notice that is currently in effect.

This Notices covers the physician practices of iMed Centers, including its employed physicians and other personnel.

Changes to this notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we received in the future. The current Notice in effect at any time will be posted on our website address listed below and will be available from the Privacy Office as well as at any of our practice locations.

www.imedcenters.com

Using and Disclosing Medical Information

How we may use and disclose medical information about you.

Treatment.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other iMed Centers personnel.

We may use and disclose medical information about you, so that we may bill for treatment and services that you received at iMed Centers, and collect payment from you, and insurance company or another party.

We may also use and disclose medical information about you for hospitalization, appointment reminders, treatment alternatives, and health-related benefits and services.

We may use and disclose medical information about you to contact you and remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if we break this agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substance, including marijuana, cocaine, etc.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescription for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use the preferred pharmacy mentioned in my intake packet. for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

FINANCIAL POLICY

The following is a statement of our financial policy. We hope this gives you a better understanding of our billing process.

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have questions or concerns, please call the office of the physician you are seeing.

Participating Plans

In this scenario, the physician you will see participates in your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. If your insurance plan requires an authorization, please be sure to obtain one before arriving to your appointment. Your provider's plan can assist you in obtaining authorization or notification to your insurance. If your plan requires a referral, please present the referral at check-in time. If you do not have a referral you might have to reschedule your appointment.

At the time of service, you will be responsible for all co-payments as outlined by your plan coverage. The co-payment is typically listed on your insurance card. iMed Centers Billing Department will then forward a bill to your insurance carrier who will inform our office if any deductible or percentage of payment is due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company.

Non-Participating Plans

In this scenario, the physician you will see does not participate in your insurance plan. Payment for services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you. Our staff will provide you with additional financial agreements to assist you in reviewing the fees.

Medicare

Most of our physicians in the practice do not accept Medicare. In the event that your physician does not participate in Medicare, you will be responsible for payment at the time of service.

Payment

Cash, check, Mastercard, Visa, Discover and American Express are recognized forms of payment.

By submitting this form, I acknowledge that the information I have provided is true and accurate. I acknowledge that I have read the iMed Centers terms and conditions, and indicate my agreement by checking the respective line below:

- Consent for Treatment (Physical Medicine, Chiropractic Care, Physical Therapy, Massage Therapy)
- HIPAA Privacy Statement
- Pain Management Agreement
- Financial Policy
- Patient Registration
- Health History

Patient Signature: _____ Date: _____



Patient Name _____ Date of Birth ____/____/____

I authorize the custodian of records of (check all that applicable):

- All records
- Laboratory/pathology records
- X-rays/radiology reports and images
- Billing and coding records
- History and physical/progress notes/summary /discharges/consultations
- Pharmacy prescription records
- Other (Describe specifically) _____

*Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

Integrated Medical Center
365 Westport Ave, Suite 3
Norwalk, CT 06851
Fax: (203) 845-0005

The information may be used /disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For review by Integrated Medical Center
- For payment / Insurance / Managed Care query
- Other: _____

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or guardian / health care proxy / conservator) _____/____/____
Date

Printed Name

Integrated Medical Center
365 Westport Ave, Suite 3
Norwalk, CT 06851
Phone: (203) 845 - 0400
Fax: (203) 845 - 0005