



# FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

## PERSONAL INJURY INTAKE

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ May we send you text reminders? Yes/No Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Gender Identity: ☐ M ☐ F ☐ Other: \_\_\_\_\_ Sex Assigned at Birth: ☐ M ☐ F

Age: \_\_\_\_\_ Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed ☐ Other: \_\_\_\_\_

Children: ☐ No ☐ Yes ☐ Decline to answer, if yes, how many children: \_\_\_\_\_ What are their ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

May we send updates to your general medical practitioner? Yes/No Name & Clinic: \_\_\_\_\_

*In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:*

Race (select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American  
☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Preferred Language: \_\_\_\_\_

## PAYMENT INFORMATION

Do <u>you</u> or <u>someone else</u> have insurance coverage for the vehicle you were in?	<input type="checkbox"/> I have <input type="checkbox"/> Someone else has coverage, Name: _____
How is this person related to you	<input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Friend, <input type="checkbox"/> Other: _____
Name of <u>your</u> Auto Insurance Carrier:	Claim Number:
Claim Adjusters Name:	Claim Adjuster's Telephone Number:
Do you know your <b>Policy Limits</b> for medical bills?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Limit is: \$
Do you have an Insurance <b>Deductible</b> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Deductible is: \$

## ATTORNEY INFORMATION

Do you have an <b>attorney</b> representing you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attorney Name: _____
if <u>Yes</u> , please provide their information:	Firm: _____

## ASSIGNMENT AND RELEASE

Scheduling an appointment reserves a time for you and no one else. If you happen to miss an appointment or need to re-schedule / cancel with less than 24 hours' notice, we will allow for 2 occurrences as we know unexpected circumstances arise. On the 3rd time, we will change you to "day of" scheduling and will no longer be able to pre-reserve appointments for you. This policy will be explained further if this should apply. Thank you for giving us **24 hours' notice if you are unable to come to a scheduled appointment.**

I \_\_\_\_\_ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment.** I agree to allow Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. I **understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Parent or guardian signature needed if patient under 18* *mm / dd / yyyy*



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### AFTER THE ACCIDENT

Symptoms **immediately** after the accident: ☐ None

- |  |   |
|--|---|
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Leg pain                 |
| <input type="checkbox"/> Head pain     | <input type="checkbox"/> Numbness/tingling        |
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Confusion/disorientation |
| <input type="checkbox"/> Arm pain      | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea                   |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Other _____              |

Were you knocked unconscious? ☐ Yes ☐ No

If **Yes**, for how long? \_\_\_\_\_

Did the drivers exchange information? ☐ Yes ☐ No

Did the police come to the scene? ☐ Yes ☐ No

If **Yes**, was a report made? ☐ Yes ☐ No

If **No**, why not? \_\_\_\_\_

Vehicles **towed after crash**? ☐ No ☐ Mine ☐ Other

Where did you **go after** the crash?

☐ Home ☐ Work ☐ Hospital ☐ Other: \_\_\_\_\_

Mode of transportation? \_\_\_\_\_

Please describe your symptoms:

a) **1-3 hrs** later? \_\_\_\_\_

\_\_\_\_\_

b) Later in the **day / night**? \_\_\_\_\_

\_\_\_\_\_

c) **Days / weeks / months** later? \_\_\_\_\_

\_\_\_\_\_

### EMERGENCY DEPARTMENT

Did you go to the **ER**? ☐ Yes ☐ No: Date \_\_\_\_\_

If **No**, why not? \_\_\_\_\_

**X-rays** taken? ☐ Yes ☐ No

If **Yes**, a) body parts imaged: \_\_\_\_\_

b) Results: \_\_\_\_\_

**CT scan** done? ☐ Yes ☐ No

If **Yes**, a) body parts imaged: \_\_\_\_\_

b) Results: \_\_\_\_\_

**MRI** done? ☐ Yes ☐ No

If **Yes**, a) body parts imaged: \_\_\_\_\_

b) Results: \_\_\_\_\_

Lab work: ☐ Yes ☐ No: \_\_\_\_\_

Diagnosis given? \_\_\_\_\_

Medications: \_\_\_\_\_

Were you given a cervical collar? ☐ Yes ☐ No

Follow-up instructions: \_\_\_\_\_

### TREATMENT HISTORY

Have you received any evaluation and/or treatment for your current injuries? ☐ Yes ☐ No

If **No**, please briefly explain why not:

\_\_\_\_\_

\_\_\_\_\_

If **Yes**, fill out below from **first to last** provider seen:

**1<sup>st</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

**2<sup>nd</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

**3<sup>rd</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

*Treatment History Cont'd...*

**4<sup>th</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

**5<sup>th</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

**6<sup>th</sup> Provider:** \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: \_\_\_\_\_

b) results: \_\_\_\_\_

Diagnosis? \_\_\_\_\_

Treatment/recommendations: \_\_\_\_\_

\_\_\_\_\_

Effects of treatment: \_\_\_\_\_

Notes: \_\_\_\_\_

**PRIOR AUTOMOBILE ACCIDENTS**

Have you been involved (driver or passenger)  
in a motor vehicle accident before? ☐ Yes ☐ No

If **Yes**, please fill out below:

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

**PRIOR INJURIES OR SYMPTOMS TO THE  
SAME AREAS**

Have you ever had any injuries or symptoms in the  
**same areas** you have now, prior to this collision?

☐ Yes ☐ No

If **Yes**, please fill out below:

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

**Year:** \_\_\_\_\_ **Injuries:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_

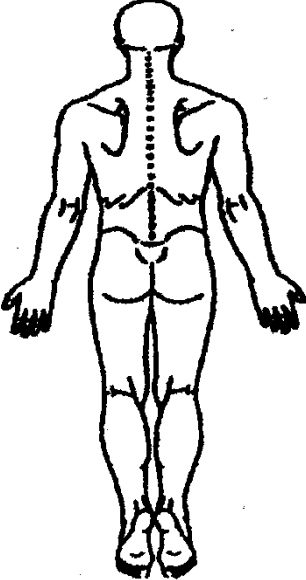
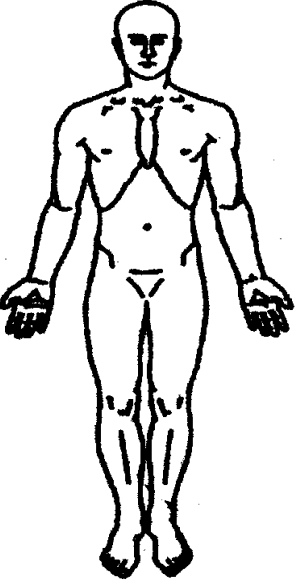
**Residual symptoms?** ☐ Yes ☐ No

If **Yes**, List: \_\_\_\_\_

# POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PATIENT INSTRUCTIONS:** It is important that this page be filled out in detail. Please read the symptoms listed below, and indicate with a check mark the appropriate box or boxes indicating when your symptoms began, taking care to note if you experienced similar symptoms before this accident. Leave the row blank if the symptom listed does not apply to you.

MARK WHERE YOU FEEL YOUR SYMPTOMS	SYMPTOM LIST (Check all that apply to you)	FELT RIGHT AFTER INJURY	BEGAN 1 – 14 DAYS AFTER INJURY	YOU HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1-3 MONTHS BEFORE THIS INJURY
<p>Use the following abbreviations to indicate on the figures below where you are experiencing symptoms:</p> <p><b>P</b> = Pain    <b>S</b> = Stiffness    <b>A</b> = Aching  <b>B</b> = Burning    <b>NT</b> = Numbness/Tingling</p> <div style="text-align: center;">  </div> <div style="text-align: center; margin-top: 20px;">  </div>	<b>PAIN / STIFFNESS:</b>				
	<input type="checkbox"/> Head				
	<input type="checkbox"/> Jaw				
	<input type="checkbox"/> Neck				
	<input type="checkbox"/> Shoulder				
	<input type="checkbox"/> Arm				
	<input type="checkbox"/> Wrist / hand / fingers				
	<input type="checkbox"/> Upper / middle back				
	<input type="checkbox"/> Chest / Breast				
	<input type="checkbox"/> Rib cage				
	<input type="checkbox"/> Low back				
	<input type="checkbox"/> Hip				
	<input type="checkbox"/> Leg / thigh				
	<input type="checkbox"/> Knee				
	<input type="checkbox"/> Ankle / foot				
	<input type="checkbox"/> Other _____				
	<b>NUMBNESS/TINGLING:</b>				
	<input type="checkbox"/> Arms				
	<input type="checkbox"/> Wrist / hand / fingers				
	<input type="checkbox"/> Leg / thigh				
	<input type="checkbox"/> Foot / toes				
	<b>OTHER:</b>				
	<input type="checkbox"/> Weakness in arms/legs				
	<input type="checkbox"/> Fatigue				
	<input type="checkbox"/> Anxiety				
	<input type="checkbox"/> Sleep Disturbance				
	<input type="checkbox"/> Sensitivity to noise				
	<input type="checkbox"/> Impaired concentration				
	<input type="checkbox"/> Vision changes				
	<input type="checkbox"/> Irritable/mood changes				
	<input type="checkbox"/> Difficulty swallowing				
	<input type="checkbox"/> Dizziness				
	<input type="checkbox"/> Forgetfulness				
	<input type="checkbox"/> Ringing in ears				
	<input type="checkbox"/> Loss of coordination				
<input type="checkbox"/> Poor balance					
<input type="checkbox"/> Sensitivity to light					
<input type="checkbox"/> Other: _____					

# REVIEW OF SYSTEMS

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**CONSTITUTIONAL** Rate your overall health (compared to others in your age group)

- |              |         |                |
|--------------|---------|----------------|
| 1. Excellent | 3. Good | 5. Poor        |
| 2. Very Good | 4. Fair | 6. Other _____ |

**HEIGHT & WEIGHT** If known, what is your:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please indicate any **current** or **past** symptoms of concern. Check all that apply, and **leave blank if not applicable**.

	Current	Past		Current	Past		Current	Past
<b>1. GENERAL</b>			<b>6. GASTROINTESTINAL</b>			<b>10. URINARY</b>		
Fever/sweats			Appetite/diet change			Pain with urination		
Fatigue			Constipation			Urinary urgency		
Fainting/dizziness			Diarrhea			Incontinence		
Chills			Heartburn/reflux			Nighttime urination		
Recent/recurrent infections			Stomach pain/bloating			Urinary tract infections		
Unexplained weight loss/gain			Nausea/vomiting			Blood in urine		
Difficulty losing/gaining weight			Belching or gas			Other:		
Other:			Bowel changes					
			Hemorrhoids					
<b>2. EYES / EARS / NOSE / THROAT</b>			Rectal bleeding			<b>IF APPLICABLE</b>		
Loss or change in vision			Jaundice (yellowing)			<b>11. Do you <u>currently</u>, or have you in the last 3 months experienced:</b>		
Hearing loss or change			Ulcers			Menstrual cramps		
Ringing/buzzing in ears			Other:			Irregular cycle		
Changes in smell						Breast soreness		
Sinus problems			<b>7. MUSCULOSKELETAL</b>			Pain with intercourse		
Changes in taste			Multiple joint pain			Hot flashes		
Voice changes/loss			Joint swelling			Genital discharge		
Trouble swallowing			Limited mobility			Breast lumps/discharge		
Other:			Reduced muscle mass			Low libido		
			Muscle weakness			Other:		
<b>3. SKIN</b>			Muscle spasm			Are you currently pregnant?	Y	N
Dry skin			Other:			If yes, what is your due date?		
Skin rash/lesions						Total number of pregnancies:		
Change in nails/hair			<b>8. PSYCHOLOGICAL</b>			Total number of births:		
Other:			Personality changes			Have you reached Menopause?	Y	N
			Mood swings					
<b>4. CARDIOVASCULAR</b>			Poor concentration			<b>IF APPLICABLE</b>		
Chest pain			Poor memory			<b>12. Do you <u>currently</u>, or have you in the last 3 months experienced:</b>		
Irregular heartbeat			Prone to stress			Erectile difficulties		
Cold fingers/toes			Prone to depression			Enlarged prostate		
Leg or ankle swelling			Anxiety			Genital sores/lesions		
Leg cramps			Anger/short temper			Penile discharge		
Hot/cold intolerance			Drug/alcohol abuse			Low libido		
Other:			Disordered eating			Other:		
			Other:					
<b>5. RESPIRATORY</b>			<b>9. NEUROLOGICAL</b>			<b>OTHER CONCERNS NOT SPECIFIED?</b>		
Difficulty breathing			Numbness/tingling			_____		
Chronic cough			Poor coordination			_____		
Chest congestion			Balance problems					
Sleep apnea			Muscle atrophy					
Allergies			Changes in speech					
Asthma/wheezing			Other:					
Other:								

## CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent or guardian signature needed if patient under 18*

*mm / dd / yyyy*

# HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## HEALTH HISTORY

Do you currently, or have you ever suffered from any of the following? (if yes please circle)

YES NO

Anemia	Colitis	Herpes	Liver disease/Cirrhosis	Sleep apnea
Aneurysm	Depression	High blood pressure	Lyme's disease	Stroke
Arthritis	Diabetes	Low blood pressure	Osteoporosis	Tendonitis
Asthma	Emphysema	High cholesterol	Pneumonia	Thyroid condition
Bleeding disorder	Gallbladder disorder	HIV/AIDS	Pancreatitis	Torn muscle/tendon
Bronchitis	Gout	Injured/pinched nerve	Recurrent sprains	Tuberculosis
Bursitis	Heart disease/attack	Irritable bowel disease	Rheumatoid arthritis	Venereal disease
Cancer	Hepatitis	Kidney stones/problems	Seizure disorder	Other: _____

### SURGICAL HISTORY / HOSPITALIZATIONS

☐ None

Year	Reason	Procedure(s)

### MEDICATIONS / SUPPLEMENTS

☐ None

Med/Supp	Dosage	Reason

### TRAUMATIC INJURY / ACCIDENTS

☐ None

Year	Trauma	Treatment

### SPECIAL TESTING (X-ray, CT, MRI, etc.)

☐ None

Year	Test/Area	Results

### ALLERGIES

☐ None

Allergy	Allergic Response

Do you have a **PRIMARY CARE PROVIDER**? YES NO

If yes, who? \_\_\_\_\_

When was your **LAST PHYSICAL**? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Note any concerns, if applicable:

## FAMILY HISTORY

Has **anyone** in your **immediate family** suffered from any of the following? (if yes, please circle)

YES NO

Aneurysm	Colon cancer	Gout	Irritable bowel disease	Skin condition
Arthritis	Depression	Heart disease/attack	Kidney stones/problems	Stroke
Bleeding disorder	Diabetes	High/low blood pressure	Osteoporosis	Thyroid condition
Cancer	Gallbladder disorder	High cholesterol	Seizure disorder	Other: _____

## PERSONAL HISTORY

Do your **DAILY ACTIVITIES** consist of any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Prolonged Sitting  | <input type="checkbox"/> Prolonged Postures |
| <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Awkward Positions  |
| <input type="checkbox"/> Light Labor        | <input type="checkbox"/> Repetitive Motions |
| <input type="checkbox"/> Heavy Labor        | <input type="checkbox"/> Mental Stress      |

Do you **EXERCISE** outside of your typical **YES NO** daily activities?

What type? \_\_\_\_\_

How many days per week? 1 2 3 4 5 6 7

How many minutes per session? 15-30 30-60 60-90 90+

What is the intensity level? Low Moderate High

Do you feel you **SLEEP WELL** at night? YES NO

Do you have trouble falling asleep? ☐ ☐

Does pain impair your sleep? ☐ ☐

If so, how many interruptions per night? \_\_\_\_\_ Time lost: \_\_\_\_\_

Do you feel rested in the morning? ☐ ☐

Please note the following **HABITS**

	None	Light	Moderate	Heavy
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SMOKING STATUS:** ☐ Never Smoked ☐ Former Smoker ☐ Occasionally ☐ Smoke Daily If smoking, start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent or guardian signature needed if patient under 18*

*mm / dd / yyyy*

## PROTECTED HEALTH INFORMATION DISCLOSURE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.
- We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.
- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.
- I understand the Notice of Privacy Practices may be revised periodically and my health information will not be disclosed unless I have given written consent. I understand a copy of the most recent version of Falling Waters, LLC's Notice of Privacy Practices will be posted in the reception area.

By signing this agreement I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before you sign this consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Special Permission Request:

I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver \_\_\_\_\_  
Name of spouse/partner/caregiver Date of birth Telephone #

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## TREATMENT CONSENT, FINANCIAL POLICY & DISCLOSURE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please feel free to ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- All procedures and treatment interventions (medications, nutraceuticals, therapies, spinal manipulation, injections, minor surgical procedures, etc.) carry with them both risks and benefits. Risks include, but are not limited to injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks, including but not limited to possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If unsure regarding a recommended treatment or procedure, there may be additional or alternative treatments available. Therefore, you are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.
- **Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.** Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services.
- **You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service; however, this is not a guarantee of payment and each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventive approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full.** At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier.
- If you have a serious health problem that requires immediate attention, you should call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call our office and inform the provider of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor / provider know if you are being treated by other healthcare providers (Physicians, Counselors, Therapists, etc.). Consult your prescribing Doctor before discontinuing medications. **It is your responsibility to disclose new injuries, symptoms, conditions, treatments, medications, supplements, surgeries or diagnostic procedures performed, as well as any changes in your symptoms, conditions, medications, supplements, contact information, or treatments by other providers between visits.**
- You are welcome to bring a friend or relative to your visits if such companionship is comfortable to you. Only registered support animals are allowed to accompany you into the clinic.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and treatment recommendations may involve encouraging you to make changes to your diet and lifestyle that can help you improve your level of health.
- Falling Waters, LLC is owned by Shawndi Stahl, PT, MPT, David McClintock, DC, and Amanda Guy whom have financial interest in its ancillary services. If you would prefer to have any ancillary services performed elsewhere we will assist you to make arrangements.

### CERTIFICATE OF CONSENT

My signature below signifies my consent to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms is complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
*Parent or guardian signature needed if patient under 18* *mm / dd / yyyy*