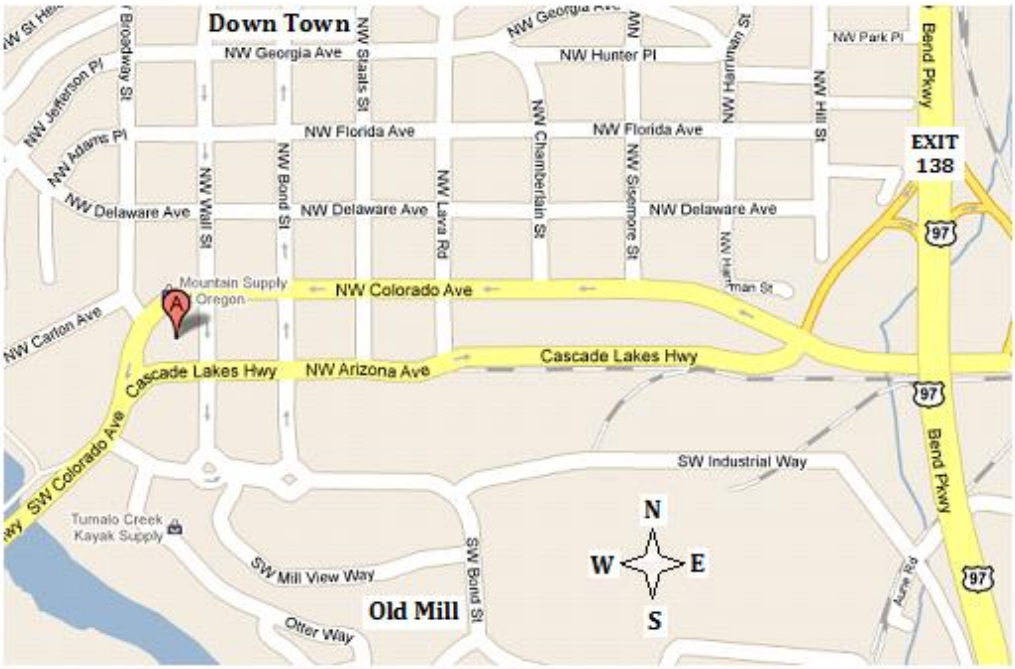
FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

APPOINTMENT CHECKLIST

- ❒ **ARRIVAL TIME:**
  Please ensure that you come to your appointment at your scheduled arrival time. If needing to reschedule, please contact the office no less than 24 hours prior to your scheduled appointment.
- ❒ **PAPERWORK:**
  Please have this packet completed prior to arriving for your appointment. If unable to do so, our front desk staff will instruct you on an earlier arrival to ensure this can be done in the office.
- ❒ **UNDER 18 YEARS OF AGE:**
  If patient is under 18 years old, parental signatures are required on all paperwork.
- ❒ **REFERRAL / PRESCRIPTION:**
  If you are being referred to our office by another doctor or practitioner, please bring the referral or prescription with you to your appointment.
- ❒ **INSURANCE CARD AND DRIVER'S LICENSE:**
  Please ensure you bring these cards with you to your appointment as we will need copies for our records.

AREA MAP



Please print the "**DIRECTIONS TO FALLING WATERS**" page from our website for more specific directions on how to locate our clinic, or if using a GPS, enter the address below.

55 NW Wall St., Ste #100, Bend, OR 97703-3200 Phone: 541.389.4321 Fax: 541.389.4420

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

ATTORNEY INFORMATION

Do you have an **attorney** representing you? ☐ Yes ☐ No Attorney Name: _____

if **Yes**, please provide their information: Firm: _____

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment**. **If 24 hours is not given, a charge of $20** will be billed to your account.

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*

INJURY HISTORY INFORMATION

Name: _____ **DOB:** _____ **Today's Date:** _____

GENERAL INFORMATION

Date of injury: _____

Time of accident: _____ ☐ a.m. ☐ p.m.

Direction of impact? ☐ Front ☐ Rear ☐ Right ☐ Left

You were the:

☐ Driver ☐ Front passenger ☐ Rear passenger

☐ Other: _____

How many people were in your vehicle? _____

How many cars were involved in the accident? _____

YOUR VEHICLE

Year: _____ Make: _____ Model: _____

Was **your car**: ☐ Stopped ☐ Rolling
☐ Speeding up ☐ Slowing down

Estimated **speed** you were traveling? _____ mph

What **direction** where you traveling? _____

Estimated cost of **damage** to your car? $ _____

Who gave the estimate? _____

OTHER VEHICLE

Year: _____ Make: _____ Model: _____

Other car was: ☐ Stopped ☐ Rolling
☐ Speeding up ☐ Slowing down

Estimated **speed** they were traveling? _____ mph

What **direction** where they traveling? _____

Estimated cost of **damage** to their car? $ _____

Who gave the estimate? _____

IMPACT

During / **after the initial** crash did your car:
☐ Hit another car / object? ☐ Roll over
☐ other: _____

Road conditions: ☐ Dry ☐ Wet ☐ Icy
☐ Other _____

Visibility: ☐ Good ☐ Poor due to _____

Were you wearing your **seatbelt**? ☐ Yes ☐ No
If **Yes**, type? ☐ Lap ☐ Shoulder ☐ Lap & Shoulder

Did your seat have a headrest? ☐ Yes ☐ No
If **Yes**, what was the position of the headrest?
☐ Low ☐ Mid-position ☐ High

Impact Cont'd…

At the time of the impact which way were you **looking**?
☐ Straight ahead ☐ Up ☐ Down
☐ To the right ☐ To the left ☐ Behind you

Was your body back **against the seat**? ☐ Yes ☐ No
If **No**, why not? _____

Were both hands on the steering wheel? ☐ Yes ☐ No
If **No**, which was on the steering wheel: ☐ L ☐ R

Was your foot on the **brake?** ☐ Yes ☐ No

Did any part of your **body strike** anything inside the vehicle? ☐ Yes ☐ No
If **Yes**, explain: _____

Did your car have airbags? ☐ Yes ☐ No
If **Yes**, did they inflate? ☐ Yes ☐ No

Was your **seat broken** in the collision? ☐ Yes ☐ No

Were you: ☐ **Surprised** by impact ☐ **Braced** for impact

Were you wearing a **hat** or **glasses**? ☐ Yes ☐ No
If **Yes**, were they **still on** after the crash? ☐ Yes ☐ No

ACCIDENT SITE

City: _____

Road/Street name: _____

Please **describe the accident** in your own words:

_____

_____

_____

_____

_____

_____

_____

CRASH DIAGRAM:

Please sketch here:

Name: _____ **DOB:** _____ **Today's Date:** _____

AFTER THE ACCIDENT

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

☐ Headache ☐ Leg pain
☐ Head pain ☐ Numbness/tingling
☐ Neck pain ☐ Confusion/disorientation
☐ Arm pain ☐ Dizziness
☐ Mid back pain ☐ Nausea
☐ Low back pain ☐ 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:

1st 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: _____

2nd 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: _____

3rd 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…

4th 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: _____

5th 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: _____

6th 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

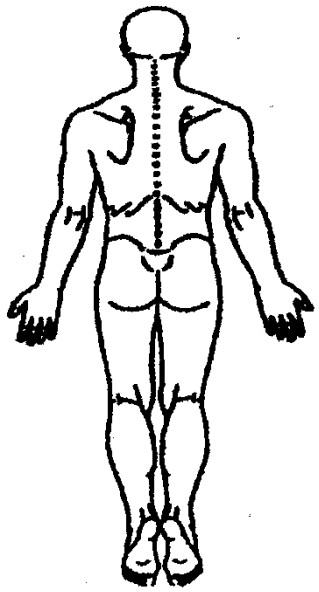
If **Yes**, List: _____

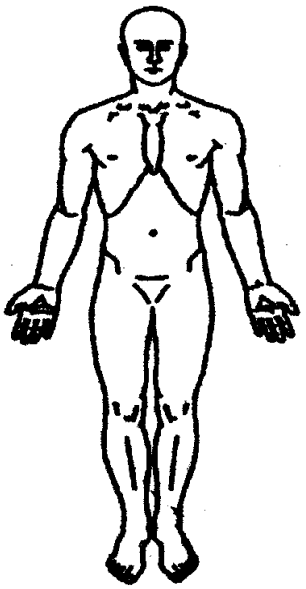
POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

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
Use the following abbreviations to indicate on the figures below where you are experiencing symptoms: **P** = Pain **S** = Stiffness **A** = Aching **B** = Burning **NT** = Numbness/Tingling	**PAIN / STIFFESS:**				
	❒ Head				
	❒ Jaw				
	❒ Neck				
	❒ Shoulder				
	❒ Arm				
	❒ Wrist / hand / fingers				
	❒ Upper / middle back				
	❒ Chest / Breast				
	❒ Rib cage				
	❒ Low back				
	❒ Hip				
	❒ Leg / thigh				
	❒ Knee				
	❒ Ankle / foot				
	❒ Other _____				
	NUMBNESS/TINGLING:				
	❒ Arms				
	❒ Wrist / hand / fingers				
	❒ Leg / thigh				
	❒ Foot / toes				
	OTHER:				
	❒ Weakness in arms/legs				
	❒ Fatigue				
	❒ Anxiety				
	❒ Sleep Disturbance				
	❒ Sensitivity to noise				
	❒ Impaired concentration				
	❒ Vision changes				
	❒ Irritable/mood changes				
	❒ Difficulty swallowing				
	❒ Dizziness				
	❒ Forgetfulness				
	❒ Ringing in ears				
	❒ Loss of coordination				
	❒ Poor balance				
	❒ Sensitivity to light				
	❒ Other: _____				





REVIEW OF SYSTEMS

Name: _____ **DOB:** _____ **Today's Date:** _____

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

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor
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
1. GENERAL		
Fever/sweats		
Fatigue		
Fainting/dizziness		
Chills		
Recent/recurrent infections		
Unexplained weight loss/gain		
Difficulty losing/gaining weight		
Other:		
2. EYES / EARS / NOSE / THROAT		
Loss or change in vision		
Hearing loss or change		
Ringing/buzzing in ears		
Changes in smell		
Sinus problems		
Changes in taste		
Voice changes/loss		
Trouble swallowing		
Other:		
3. SKIN		
Dry skin		
Skin rash/lesions		
Change in nails/hair		
Other:		
4. CARDIOVASCULAR		
Chest pain		
Irregular heartbeat		
Cold fingers/toes		
Leg or ankle swelling		
Leg cramps		
Hot/cold intolerance		
Other:		
5. RESPIRATORY		
Difficulty breathing		
Chronic cough		
Chest congestion		
Sleep apnea		
Allergies		
Asthma/wheezing		
Other:		

	Current	Past
6. GASTROINTESTINAL		
Appetite/diet change		
Constipation		
Diarrhea		
Heartburn/reflux		
Stomach pain/bloating		
Nausea/vomiting		
Belching or gas		
Bowel changes		
Hemorrhoids		
Rectal bleeding		
Jaundice (yellowing)		
Ulcers		
Other:		
7. MUSCULOSKELETAL		
Multiple joint pain		
Joint swelling		
Limited mobility		
Reduced muscle mass		
Muscle weakness		
Muscle spasm		
Other:		
8. PSYCHOLOGICAL		
Personality changes		
Mood swings		
Poor concentration		
Poor memory		
Prone to stress		
Prone to depression		
Anxiety		
Anger/short temper		
Drug/alcohol abuse		
Disordered eating		
Other:		
9. NEUROLOGICAL		
Numbness/tingling		
Poor coordination		
Balance problems		
Muscle atrophy		
Changes in speech		
Other:		

	Current	Past
10. URINARY		
Pain with urination		
Urinary urgency		
Incontinence		
Nighttime urination		
Urinary tract infections		
Blood in urine		
Other:		

IF APPLICABLE

11. Do you currently, or have you in the last 3 months experienced:

	Current	Past
Menstrual cramps		
Irregular cycle		
Breast soreness		
Pain with intercourse		
Hot flashes		
Genital discharge		
Breast lumps/discharge		
Low libido		
Other:		

Are you currently pregnant? Y N

If yes, what is your due date? _____

Total number of pregnancies: _____

Total number of births: _____

Have you reached Menopause? Y N

IF APPLICABLE

12. Do you currently, or have you in the last 3 months experienced:

	Current	Past
Erectile difficulties		
Enlarged prostate		
Genital sores/lesions		
Penile discharge		
Low libido		
Other:		

OTHER CONCERNS NOT SPECIFIED?

_____ | |

_____ | |

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)

TRAUMATIC INJURY / ACCIDENTS ❒ None

Year	Trauma	Treatment

SPECIAL TESTING (X-ray, CT, MRI, etc.) ❒ None

Year	Test/Area	Results

MEDICATIONS / SUPPLEMENTS ❒ None

Med/Supp	Dosage	Reason

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?

- ☐ Prolonged Sitting
- ☐ Prolonged Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Prolonged Postures
- ☐ Awkward Positions
- ☐ Repetitive Motions
- ☐ Mental Stress

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? ☐ ☐

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

- 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

Please note the following **HABITS**

	None	Light	Moderate	Heavy
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

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. Due to allergies and patient sensitivities, only registered service animals as defined by Title II and III of the ADA are allowed to accompany you into the clinic. Please have your animal clearly marked by a vest or other ID.
- 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*