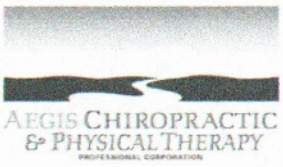


New Patient Registration

Date:____/____/_____

Patient Name: _____ Sex: ___M ___F
Last First M.I.

Preferred Name and/or Pronoun:_____

Parent/Guardian name & relationship (if patient is a minor): _____

Permanent Address: _____
Same as Local____ Street City State Zip

Local Address: _____
Street City State Zip

Date of Birth:____/____/____ Age: ___ SS#: _____ Marital Status: S M P D W

Best time & Phone Number to reach you: _____ E-Mail _____

Employer/School Name:_____Occupation:_____Full time Student Y N

Emergency Contact:_____ _____ _____
Name Relationship to Patient Phone

Primary Care Physician:_____

Referring Physician:_____
Name & Specialty (orthopedist, Surgeon, Neurologist, etc.) Address Phone

When is your follow up visit with the Referring Physician? _____

Whom may we thank for referring you? (Other than your physician) _____

Insurance Information: (In order to Bill Insurance WE MUST have a copy of your card):
Primary Insurance Company:_____ Covered by additional Insurance? Y N

Policy ID#/Claim#:_____ Group#:_____

Subscriber's Name:_____ Subscriber's Employer:_____
Is Patient the Subscriber? Y___ N____ If No, then:

Relationship to Patient:_____ Subscriber Date of Birth:____/____/____

Injury Information: Circle one: Work Comp Motor Vehicle Accident Home Other Date of Injury__/__/____

Attorney/Claim Adjuster/Vocational Rehab Counselor:

Name:_____

Address:_____
Street City State Zip

Phone:_____ Fax:_____ Email:_____

Patient Medical History

Patient Name:_____ **Date:**_____

1.) What condition are you here for?_____ Date of Injury/Onset?_____
2.) Have you ever had these symptoms before? (circle one) Y or N If yes, when?_____
3.) Have you ever had physical therapy or any other treatment for this condition? (circle one) Y or N If yes, when and where?_____
4.) Have you had related surgery? (circle one) Y or N
Describe:_____

5.) Check all which apply to your symptoms:

____ Work related injury
____ Motor vehicle accident
____ Cause Unknown
____ Recurrence of previous injury
____ Injury related to lifting
____ Athletic/Recreational injury

6.) **Rate your average pain intensity (circle one):** 0 1 2 3 4 5 6 7 8 9 10 (worst)

7.) Do you have now, or have you ever had any of the following: (Please check all that apply)

____ Arthritis (Osteo or Rheumatoid)
____ Diabetes (DM/DI)
____ Heart Attack
____ Heart Palpitations
____ Heart Disease/Chest Pain/Angina
____ High/Low blood pressure
____ Headaches/Migraines
____ Dizziness/Fainting
____ Nausea/Vomiting
____ Ringing in ears
____ Asthma/Breathing difficulties
____ Infectious diseases: (TB, Hepatitis, AIDS)
____ Are you pregnant?
____ Hernias
____ Allergy to aspirin
____ Allergy to Heat/Cold
____ Intolerance to Tylenol/Advil/Naprosyn
____ Other allergies (list below)
____ Lyme Disease
____ Infections
____ Neurological Problems
____ Ehlers-Danlos
____ Stroke/Circulation/Vascular issue
____ Parkinson Disease
____ Multiple Sclerosis
____ Seizures/Epilepsy
____ Cancer
____ Kidney/Liver Disease
____ Vision Problems
____ Hearing Problems
____ Difficulty Walking
____ Joint pain or swelling
____ Loss of balance
____ Coordination problems
____ Low Blood Sugar
____ Head injury/TBI/Concussion
____ Skin abnormalities
____ Metal/Wire Implants
____ Recent fractures
____ Bowel/Bladder problems
____ Prior Surgeries
____ Pacemaker

If you answered yes to any of the above, please briefly explain and give approximate dates of condition(s):

_____

_____

_____

8.) Are you presently taking any medications? (circle one) Y or N If yes, please list the type of medication and for what condition:

_____

_____

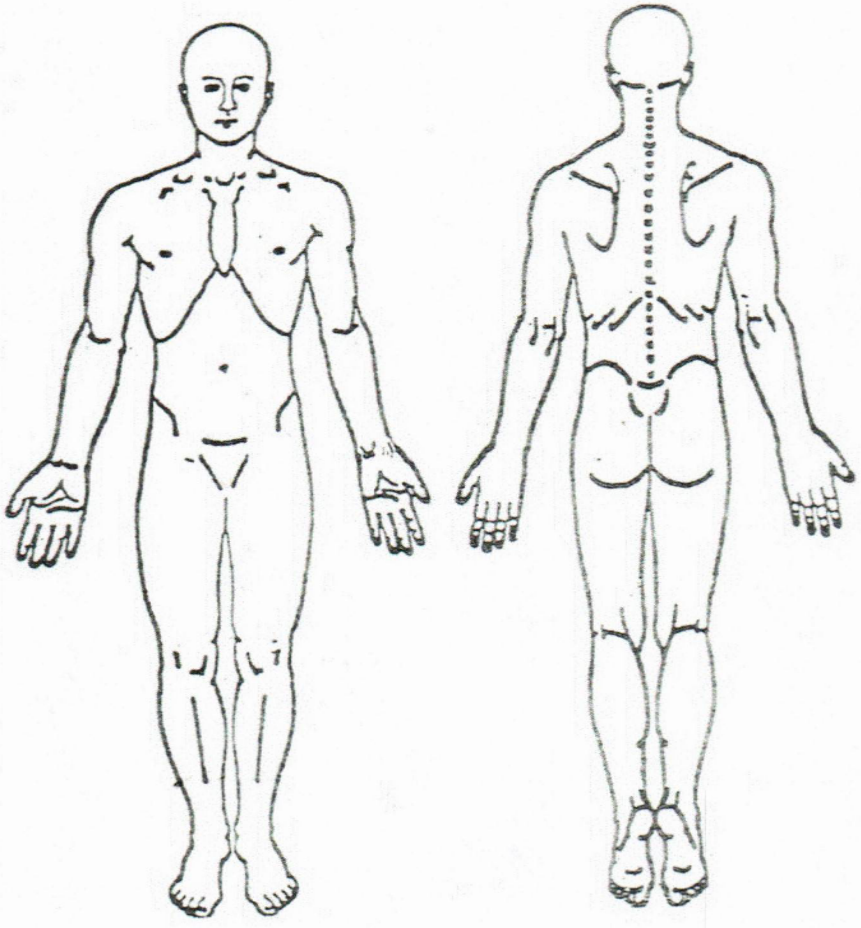
_____

_____

9.) Functional Status/ Activity Level: (Please check or circle all that apply)

_____ Difficulty with locomotion/mobility: Bed Mobility, Transfers (such as moving from chair to bed), Gait (walking)
_____ Difficulty with self care (such as bathing, dressing, eating, toileting)
_____ Difficulty with community or work activities: work/school, recreational activities
_____ Difficulty with home management (such as household chores, shopping, driving, care of dependents)
_____ Difficulty with sleeping

10.) Please indicate on the body below where pain is located, circle type of pain. Does pain travel? Y or N
S = Sore A=Achy B=Burning tt=Tight T=Tingling N=Numbness SP=Spasms



11.) What are your goals for therapy?

_____

_____

_____

Attendance Policy, Consent to Treat & HIPAA

Aegis Chiropractic & Physical Therapy strives to provide each patient with the highest quality care while accommodating patient schedules. We reserve time slots for each patient in order to minimize waiting time and assure continuity of care. Your consistent attendance of the planned treatment regimen is paramount to your full recovery!

Please do not come to Aegis if you feel unwell or have COVID symptoms. We request as much advance notice as possible if you will not keep your appointment. Aegis Chiropractic & Physical Therapy also reserves the right to charge you a $60 No-Show fee for any missed appointments for which you do not call us and a $25 for any cancellation on the day of your appointment. Your insurance will not be billed for the visit.
If you are going to be late for an appointment, please let us know as soon as you can. We will do our best to accommodate you; however, there may be times we will need to reschedule.

Consent to Treat

I give permission for Aegis Chiropractic & Physical Therapy to provide the medical treatment appropriate and necessary for the rehabilitation of
_____'s current physical condition.
(Name of Patient)

Consent to Treat Minor

Aegis Health Partners requires authorization to treat minor children in the absence of the patent or legal guardian. I , (print Parent(s)/Legal Guardian(s) name) _____, hereby give my consent for my dependent to receive medical treatment/procedure(s) provided by Aegis Chiropractic & Physical Therapy.

Name of Minor: _____ DOB: _____

Privacy

Aegis Chiropractic & Physical Therapy understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. If you are unaware of these policies, please ask us for a copy. Any changes to the HIPAA privacy Act, effective April 14, 2003 or patient rights will be available in our office. I agree to and understand the above policies. You also agree to receive emails and text messages from Aegis Chiropractic & Physical Therapy and our direct affiliate Aegis Real Estate LLC.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

Payment Policy and Financial Agreement

Thank you for choosing Aegis Chiropractic & Physical Therapy for your healthcare needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement and sign below.

Insurance

We are eager to help you receive the maximum allowable benefits for your healthcare needs. You should note that insurance coverage is a contract between you and your insurance company. As medical care providers, our relationship is with you, not your insurance company but we are happy to help by sending information to your insurance company. It is your responsibility to understand your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy we may verify coverage, obtain authorization and bill your insurance company for you. However, we do expect payment for all services and you are ultimately responsible for your bill. There are no guarantees of benefit reimbursement until claims are received and processed by your insurance company. We will require you to assign all insurance company payments directly to our office for payment of professional services. If your request that your insurance company pays you directly, we will require full payment when services are rendered.

Patient Responsibility & Payment

Payment for copays and deductibles will be due at time of service. You are ultimately responsible if your insurance denies a claim for any reason. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing Manager. Anything over 30 days is considered past due and interest may accumulate at a rate of 1.5% per month. Failure to pay will result in your account being referred to a collection agency or attorney which can affect your credit. If you do not have insurance, payment in full will be due at time of service. Checks returned for insufficient funds will result in a $25.00 returned check fee.

Payment Options- Credit Card on File

Aegis Chiropractic & Physical Therapy stores your credit card data using an encrypted and tokenized system at an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards. You can receive an email or paper receipt for any charges. If you prefer to not have your credit card on file, you may pay with a check or cash. Outstanding balances over 30 days will be charged to your card on file. I authorize Aegis Chiropractic & Physical Therapy to debit the card on file for any patient responsibility, including but not limited to co-pays, remaining balance, payment plans, late cancellations and no-show fees. I understand that I can update my card information on file in writing at any time. In fact, it is my responsibility to notify our office of any updates or changes to the credit card on file associated with this agreement as soon as possible.

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to an attorney for collection. If this is necessary, I agree to reimburse Aegis the fees of any collection expenses, such as attorney fees and court costs which we incur in such collection efforts.

Patient Signature	Printed Name	Date
Parent/Guardian Signature	Printed Name	Date

Aegis Chiropractic and Physical Therapy

241 Russell St. Hadley MA 01035
Phone: 413-586-5552 Fax: 413-586-3330

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name:		Date of Birth:	
Street Address:	City:	State:	Zip:
Phone Number:			

I give Permission to Aegis Chiropractic and Physical Therapy to discuss (via verbally, email, text) the following medical information about me. This may include:

Medical information pertaining to my symptoms, diagnosis, medication treatment plan, scheduling appointments, and medical billing information related to charges and fees.

Aegis Chiropractic and Physical Therapy has my permission to discuss the above information with:

Name	Phone	Relationship to Patient

Medical records are defined as: All health information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all healthcare information in your/our possession, whether generated by you/us or any other source, as well as health care information.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law. Authorization will expire in **12 months** unless otherwise specified.

Expiration Date:_____

Patient Signature: _____ Date _____

Or Legal Representative/Guardian_____Date_____
Relationship to Patient _____Date_____

Office use only: Information noted in Webpt and on Patient Chart Date:_____By:_____