MyoCore New Patient Intake Paperwork

1 Patient Information

Legal Name: (Last) _____ (First) _____ (Middle Initial) _____ (Date) _____

Sex: ☐ Male ☐ Female ☐ Intersex Pronouns: _____

Gender Identity: ☐ Male ☐ Female ☐ FTM ☐ MTF ☐ NB/GNC ☐ Not listed ☐ Decline to Answer

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ City: _____

State: _____ Zip: _____ ☐ Married ☐ Single ☐ Partnered ☐ Widowed ☐ Children How many: _____

Social Security # or DL # _____ Age: _____ Birth Date: _____ Patient Employer/School: _____

Occupation: _____ Address: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? (Please select):

☐ Online (Google, etc.) ☐ Insurance Portal ☐ Handout/Flyer

Friend/Family/Current Patient (Name): _____

Event: _____

Please select your preferred method of contact for our automated appointment reminders:

☐ Text reminder to cell # ☐ Call reminder to cell # ☐ Decline all reminders

By checking the "Preferred method of contact" box, you consent to receive voice, text, email communications regarding your patient relationship with MyoCore, including, but not limited to, appointment reminders and requests for contact. Standard messaging rates and other charges may apply.

Initial: _____

2 Payment/Insurance Information

Who is financially responsible for this account: ☐ Self-Pay or ☐ Other (Name): _____

If 'Other', what is relationship to patient? _____

If insured, who is the main subscriber/policy holder? _____

Birth Date: _____ Phone: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Health Insurer Insurance Co Name: _____ ID # _____ Group # _____

☐ Government Program Name: _____ ID # _____

Is this policy associated with an ☐ HSA ☐ FSA ☐ HRA? ☐ Yes ☐ No

Is patient covered by additional/ secondary insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ ID # _____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent to treatment by MyoCore, 3) assign to MyoCore, any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by MyoCore, authorize their payment directly to MyoCore, and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to MyoCore (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to MyoCore releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of MyoCore's Notice of Privacy Practices.

_____ _____

Printed name of Patient, Parent, Guardian or Personal Representative | Signature of Patient, Parent, Guardian or Personal Representative

Relationship: _____ Date: _____

3 Medications

1) _____

2) _____

3) _____

Pharmacy Name: _____

Pharmacy Phone: (_____) _____

☐ None

Vitamins/Supplements

1) _____

2) _____

3) _____

4) _____

☐ Daily ☐ Weekly ☐ Occasionally

☐ None

Allergies

1) _____

2) _____

3) _____

4) _____

How often do they occur?

_____

☐ None

4 Family History

Autoimmune Dis.	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	☐ Other	_____
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No		
Clotting Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No		

5 Medical History

Name of pirmary care doctor: _____ Name of other doctor(s): _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____

Menstrual Period (LMP): _____ MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐ Yes ☐ No	Chemical Depend./ Alcoholism	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Clotting Disorder	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Epilepsy/Seizure Dis.	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	MS	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No			Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No	If yes, how many weeks? _____		Double Vision	☐ Yes ☐ No	☐ Other _____	

6 Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐ Front ☐ Rear ☐ Side/Passenger ☐ Side/Driver ☐ Seat Belt ☐ Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

_____

_____

Chiropractic Care Description:

_____

_____

7 Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐ Front ☐ Rear ☐ Side/Passenger ☐ Side/Driver ☐ Seat Belt ☐ Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

_____

_____

Chiropractic Care Description:

_____

_____

8 Physical & Trauma Information

Please indicate any physical and/or trauma occurences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Retired _____

Work Injuries: ☐ Yes ☐ No If yes: _____

Sport Activities: _____

Sport Injuries: ☐ Yes ☐ No If yes: _____

Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy _____

Home Injuries: ☐ Yes ☐ No If yes: _____

Habits: ☐ Nicotine ☐ Alcohol ☐ Coffee/Caffeine Drinks ☐ High Stress Level ☐ None

How Much? _____ How Often? ☐ Daily ☐ Weekly ☐ Occasionally

Falls: ☐ Yes ☐ No If yes: _____

Head Injuries: ☐ Yes ☐ No If yes: _____

Dislocations: ☐ Yes ☐ No If yes: _____

Broken Bones: ☐ Yes ☐ No If yes: _____

Surgeries: ☐ Yes ☐ No If yes: _____

Your Birth Delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown

Complications: ☐ Breech ☐ Fetal Distress ☐ CPD ☐ Placenta Previa ☐ Premature ☐ Umbilical Cord ☐ Meconium Aspiration ☐ None

9 Primary Complaint

Please note ONE complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

☐ Denied

Primary complaint: _____

Please describe the condition: _____

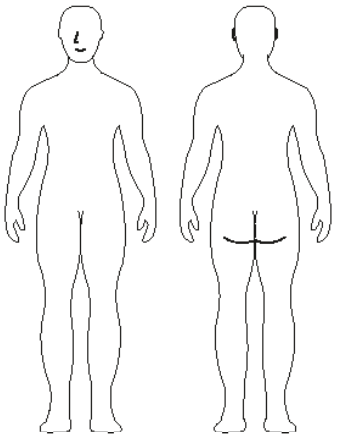
When did your symptoms first appear? _____

Most recent occurence date: _____

What do you think caused this problem? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain ...at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

...at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

(please circle) ...at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

10 Additional Complaint I

Please note ONE complaint in the following section. The Additional Complaint I is any other problem/complaint you may be experiencing that you would like the office to be made aware.

☐ Denied

Additional complaint _____

Please describe the condition _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

11 Additional Complaint II

Please note ONE complaint in the following section. The Additional Complaint II is any other problem/complaint you may be experiencing that you would like the office to be made aware.

☐ Denied

Additional complaint _____

Please describe the condition _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

12 Is there anything else you would like the Doctor of Chiropractic to know?

FOR OFFICE USE ONLY

Clinical Comments:

Examiner's Name: _____ Examiner's Signature: _____ Date: _____

Physician/Provider Name: _____ Physician/Provider Signature: _____ Date: _____

MyoCore
Personalized Pain Care

AUTHORIZATIONS & AGREEMENTS

Informed Consent and Terms of Acceptance

Chiropractic care, like all forms of healthcare, offers considerable benefits and may also carry some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications reported secondary to chiropractic care include sprain/strain injuries, muscle spasms for short periods of time, aggravation and/or temporary increase in symptoms, lack of improvement in symptoms, dislocations, disc injuries, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. You cannot expect the doctor to be able to anticipate and explain all risks and complications, and you agree to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in your best interests.

Prior to your receiving chiropractic care from MyoCore, a health history and physical examination will be completed. These procedures are performed to assess your specific condition. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you, along with any recommended future chiropractic care.

We do not offer to diagnose or treat any disease regardless of what the disease is called, nor do we offer advice regarding treatment prescribed by others. We only offer to diagnose either segmental and somatic dysfunction of the spine or neuro-musculoskeletal conditions.

During the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider. You understand and have been informed that you have the right to a second opinion and secure other opinions if you have concerns as to the nature of your symptoms and treatment options. You also understand that there are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to; self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

You hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy and any supportive therapies for yourself (or for the patient for whom you are the parent or legal guardian) by the MyoCore doctor of chiropractic and supporting healthcare staff. You acknowledge that you have had an opportunity to discuss with the MyoCore doctor of chiropractic the nature and purpose of chiropractic adjustments and procedures and that you understand and are informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure.

Payment and Assignment of Benefits

In consideration of any services provided by MyoCore, you agree to: 1) be primarily responsible for all charges owed to MyoCore, including attorney fees, court costs, and other expenses of collection, 2) irrevocably assign and transfer to MyoCOre, all right, title, and interest to health insurance or reimbursement benefits to which you are entitled for the purpose of payment of the charges owed to MyoCore, and 3) authorize payment of such benefits directly to MyoCore.

If you have health insurance, you acknowledge that our verification of your health insurance benefits is only an estimate of benefits payable to you, if any, and that health insurance benefits may vary due to the coverage the plan sponsor offered or the coverage you purchased, you or the plan sponsor's failure to pay premiums, termination of the plan by the sponsor, your failure to otherwise remain eligible (e.g., not maintaining full-time employment status), error, and other causes. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not covered by health insurance.

If you have a health savings account (HSA), flexible spending account (FSA), or a health reimbursement account (HRA), you must inform us so that we can make appropriate arrangements for payment.

You acknowledge that our verification of health reimbursement benefits is only an estimate of benefits payable to you, if any, and that health reimbursement benefits may also vary. We do not directly bill to any HSA, FSA, or HRA plan, but, depending

upon your plan provisions, automatic withdrawals may occur when we submit charges to any primary health insurer. Any refund or reimbursement to an HSA, FSA, or HRA account cannot exceed your out-of-pocket contribution toward any treatment. You further acknowledge that you are primarily responsible for all charges owed to MyoCore, whether or not eligible for health reimbursement benefits.

If you are a Medicare, Medicaid, or other government healthcare program participant, you assign, and request that payment of, all benefits be made on your behalf for healthcare services rendered, directly to us. You also authorize any holder of medical or other information about you to release to the Centers of Medicare and Medicaid Services or other applicable government program office and its agents, any information needed for payment of benefits.

Medicare Release
You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about you to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. You authorize payment or benefits to us on your behalf.

Medical Records Privacy and Consent to Release Information
MyoCore respects your privacy. We comply with the Health Insurance Portability and Accountability Act ("HIPAA"), and we may release your "protected health information," as defined by HIPAA, only as allowed by law, such as:

- For your treatment and care coordination;
- To obtain payment for your healthcare;
- To your family, friends, or others you identify who are involved with your healthcare or your healthcare bills, unless you object; or
- In response to a subpoena, court order, or otherwise in connection with a claim, lawsuit, or proceeding in which you are involved.

We do not sell any of your "protected health information" for marketing or any other purpose. Accordingly, you consent to us releasing your "protected health information" only as allowed by law. You also acknowledge receipt of MyoCore's Notice of Privacy Practices.

General Conditions
You are responsible for your personal property while on our premises. The only time we are responsible for any personal property on our premises is when we accept it from you for safekeeping and acknowledge it in writing.

As the healthcare you are seeking is non-emergency care, you acknowledge that we have the right to decline treatment in our sole discretion.

A $35 fee will be automatically assessed when a minimum of 4 hour notice for an appointment cancellation or request to reschedule is not given.

We do not discriminate on the basis of any legally protected classification.

Consent to Evaluate and Adjust a Minor Child

You, _____, being the parent of legal guardian of _____, have read and fully understand the above Terms of Acceptance and hereby grant permission for your child to receive chiropractic care.
Signature: _____ Date: _____

NO REVISIONS OR CHANGES TO THIS FORM, BY YOU, WILL BE ACCEPTED BY MYOCORE.
You have read, or have had read to you, the above Authorizations and Agreements, and understand and agree to the provisions contained within. You have also had an opportunity to ask questions about its content, and by signing below, you agree to the above-named procedures, and acknowledge that you are the patient (or the parent or legal guardian of the patient) seeking healthcare from MyoCore. You intend this consent to cover the entire course of treatment for your present condition and for any future condition(s) for which you seek treatment.

_____ _____
Signature of Patient or Responsible Party; parent, guardian or other representative Date

_____ _____
Signature of Policyholder Date:

_____ _____
Signature of Witness to signing of consent form Date: