645 N. Jessica Brooke Circle Suite C Wasilla, AK 99654
Phone: (907)631-0600 Fax: (907)631-3032

PATIENT REGISTRATION

Patient Name: ____ Email: ______________________________
(Last) (First) (M.I.) *(For Appointment Notifications Only)*

Date of Birth: _____/_____/_____ SSN # _______ - ___ - ______ Sex: M F Marital Status: ________

Address: _________________________________ City: _______________ State: _____ Zip: _____________

Phone: Home ( ) _______-__________ Cell ( ) _______-__________ Employer: _______________

Current Injury

Date of Injury: _______________ Injury Description: ____

Have you missed work due to this injury? Y N If so, how often?___________________________________

Have you had surgery for this injury? Y N If so, what procedures and how many?____________________

____

Have you sought care from any other medical providers for this injury/episode? Y N

Alcohol Consumption: Y N Frequency:__________ Smoking: Y N Amount: ___________________

Exercise: Y N Frequency and Duration:__________________ If female, are you pregnant? Y N

Medical History

Primary Care/Referring Physician ____

Current Medications and Dosages: ____

Past Medical and Surgical History: ____

____

CONSENT FOR CARE AND TREATMENT

I, _______________________, do hereby agree and give my consent for Jaded Body Wellness & Spine Institute, LLC to furnish the medical care and treatment considered necessary and proper in assessing or treating my physical and mental condition.

Signature Patient/Guardian__________________________________ **Date**: _______________

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INSURANCE INFORMATION

(PLEASE FILL OUT OR PROVIDE INSURANCE CARD AND ID)

Primary Insurance:

Carrier's Name: ____ **Carrier's D.O.B**:______________________
Carrier's Social Security # _______-_______-_______ Phone No. ( ) _______-__________________
Address: _____________________________________ City: __________________ State: _____ Zip: _______
Policy/I.D. #: ______________________ Group #________________ Group Name: _____________________
Employer Name: ____

Secondary Insurance:

Carrier's Name: _______________________________________ **Carrier's D.O.B.:** _______________________
Carrier's Social Security # ______ - ______ - ______ Phone No. ( ) _______-____________________
Address: ____________________________ City: _________________________ State: _____ Zip: _______
Policy/I.D.: _________________________Group #___________________ Group Name: __________________
Employer Name:____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third party payers to Jaded Body Wellness & Spine Institute, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Signature Patient/Guardian: _______________________________________ **Date**: ______________

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PATIENT SUBJECTIVE

Rate your pain on a scale from **0** (no pain) to **10** (excruciating pain that is disabling)

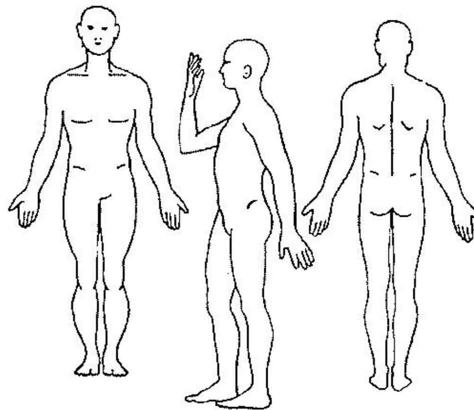
At the best moment in the last 48 hrs: _______ During the night: _______
At the worst moment in the last 48 hrs: _______

Does your pain wake you up at night? YES NO
Does your pain fluctuate based on your positions or activities? YES NO
Does your pain follow a pattern whereby it is worse in the **AM** or **PM** (circle one if yes)? YES NO
Does your pain radiate from one area to other area? YES NO

Is your pain **constant** or **intermittent** (circle one)?

Please list any activities of daily living that are painful or limited due to your injury?
____

Please indicate location of pain on diagram:



Did your referring MD give you any instructions (i.e.: for exercise, weight-bearing, weaning from crutches, use of a brace)? YES NO Please elaborate:

____

____

What are your goals for treatment?

____

____

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PATIENT AGREEMENT

- Physical therapy is by physician referral and appointment only, unless your insurance is direct access approved.
- If a patient is more than 15 minutes late for an appointment, **Jaded Body Wellness & Spine Institute, LLC** reserves the right to cancel the appointment and charge a $50 late cancellation fee.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE PATIENT WILL BE CHARGED** a $50.00 late cancellation fee.
- Full payment of your outstanding deductible and all initial co-payments are to be made directly to *Jaded Body Wellness & Spine Institute, LLC* at the time of the initial visit. Subsequent physical therapy co-payments (and cancellation fees assessed) are to be made at the time of each visit.
- Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.
- If any changes are made to patient insurance/payment coverage, patient agrees to alert Jaded Body Wellness & Spine Institute, LLC as soon as possible to these changes.
- Jaded Body Wellness & Spine Institute, LLC will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made the day of your appointment.
- In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.
- If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to Jaded Body Wellness & Spine Institute, LLC, including court costs, collection agency fees and attorney fees.

I, ______________________________________, agree to treatment on the above terms:

____ _______________

Signature Patient/Guardian **Date**

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PATIENT HIPAA AWARENESS AGREEMENT

With my permission, Jaded Body Wellness & Spine Institute may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jaded Body Wellness & Spine Institute's, LLC Notice of Privacy Practices, located at our front desk, for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the offices of Jaded Body Wellness & Spine Institute, LLC may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of Jaded Body Wellness & Spine Institute, LLC may mail to my home, or other designated location, any items that assist The Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal" and "Confidential". I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO. However, The Practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, I am allowing Jaded Body Wellness & Spine Institute, LLC to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that The Practice has already made disclosures in reliance upon my prior consent.

__________________________________ _________________

Signature of Patient/Guardian **Date**

__________________________________ _________________

Print Patient's/Guardian's Name **Date**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

I authorize **Jaded Body Wellness & Spine Institute,LLC**
To request and receive healthcare information of the patient named above.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ________

____

☐ All healthcare information

☐ Other: ____

Signature Patient/Guardian: ______________________ **Date Signed**: ______________

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AGREEMENT FOR NON-COVERED SERVICES AND SERVICES DETERMINED TO BE "NOT MEDICALLY NECESSARY"

The office of JADED Body Wellness & Spine Institute, LLC has explained to me that the benefits for services requested may not be considered "Medically Necessary" by my insurance company. I have decided to receive the following services which may be non-covered or considered "Not Medically Necessary". JADED Body Wellness & Spine Institute, LLC will do their best to verify my benefits at time of service; however, it is a quote of benefits and not a guarantee of payment. Since an insurance plan is a contract between me and the insurance carrier, it is ultimately my responsibility to be aware of my insurance benefits. Any services not covered or deemed "not medically necessary" are my financial responsibility. I have agreed to receive any services necessary from the list below.

CPT Codes	Service	Price
97161,2,3	Initial Evaluation (Low, Medium, High)	$180
97164	Re-evaluation	$115
97140	Manual Therapy	$75
97110	Therapeutic Exercise	$93
97010	Hot/Cold Pack Therapy	$75
97018	Paraffin	$50
97530	Therapeutic Activity	$72
97035	Ultrasound Therapy	$60
97116	Gait Training	$80
97033	Iontophoresis	$80
97535	Self-Care Management	$70
97014	Electro-Stimulation	$55
97032	Electro-Stimulation (1x1)	$55
97012	Mechanical Traction	$56
97112	Neuromuscular Re-education	$86
97760	Orthotic Fitting/Training	$67
97762	Orthotic Follow-up	$75
L3020	Right Custom FAB Orthotic	$180
L3020	Left Custom FAB Orthotic	$180

I am aware these services may or may not be determined by my health insurance policy and/or certificate to be "not medically necessary" and may or may not become non-covered services for the complete duration of treatment for my illness, injury or condition. If the services are not covered or considered not medically necessary by my health insurance policy and/or certificate, I agree to be financially responsible for such services.

____ __________________

Signature of Patient/Guardian **Date**