ASHEVILLE NON SURGICAL ORTHOPEDICS
675 BILTMORE AVENUE, SUITE F
ASHEVILLE, NC. 28803
(828) 417-9913

PATIENT INTAKE FORM

Today's Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Date of Birth: ____/____/____

Home Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell Phone: _____ Work Phone: _____ EXT: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Marital Status (Circle One): M S W D

How did you hear about Asheville Non Surgical Orthopedics?

_____

Primary Care Physician: _____

Clinic or Practice Name: _____

Address: _____ Phone: _____

Social History:

Employer: _____ Occupation: _____

Do you use any of the following (Check all that may apply):

	YES	NEVER	QUIT	AMOUNT PER DAY
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Last Name: _____ First Name: _____

Reason for today's visit and current symptoms:

_____

_____

When did this condition begin: _____ Have your symptoms changed since, if so in what way:

_____

_____

Is it constant: _____ What makes your symptoms better or worse: _____

_____

Does any discomfort travel to other areas of the body: _____ If so please describe: _____

_____

Rate your discomfort (1-10) Best: _____ Worst: _____

Has this complaint been previously evaluated: _____ Have you had any imaging: _____

What treatment, if any, have you received and what was the outcome: _____

_____

_____

Any known allergies: _____

Any additional symptoms (Circle all that may apply):

Muscle Spasm Burning/Tingling Numbness Muscle Weakness Joint Stiffness Swelling

Additional Comments you may want to share with the Dr: _____

_____

_____

****

Office Use Only:

DOB: ____/____/_____ MRN: _____

Last Name: _____ **First Name:** _____

Current Medications and/or supplements	Dosage	Frequency

Patient Medical History:

Condition	Date	Treatment/Outcome

Previous Surgical History:

Procedure	Date	Length of stay

Family Medical History:

Family Member (Maternal or Paternal)	Illness	Deceased	Living

Last Name: _____ First Name: _____

COVID-19 SCREENING QUESTIONNAIRE

Within the past 14 days:

1) Have you or someone you live with been experiencing new onset of following symptoms: (Check all that apply)

____ Fever or chills
____ Diarrhea
____ Headache
____ Muscle or body aches
____ Congestion/runny nose
____ Fatigue
____ Sore throat/Cough
____ Nausea & Vomiting
____ New loss of taste/smell
____ Shortness of breath or difficulty breathing

2) Have you or someone you live with been tested positive for COVID-19?

____ Yes ____ No

3) Have you or someone you live with been tested and are waiting on results?

____ Yes ____ No

4) Have you or someone you live with been exposed to an individual with a positive COVID-19 diagnosis?

____ Yes ____ No

Today's Date: ____/_____/_____

Last Name: _____ First Initial: _____

Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: _____

Patient's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐☐☐☐

Expiration Date: _____

I, _____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date

Treatment Consent Form

ASHEVILLE NON-SURGICAL ORTHOPEDICS, PLLC

Please read carefully, sign, and date

SERVICES OFFERED

ORTHOBIOLOGIC AND NEUROMUSCULOSKELETAL MEDICINE

Our office blends several styles of medicine to create an individualized and personalized practice that is highly patient focused. The patient is the center of our philosophy, which involves optimum health and balance in the body, and mind. All of our systems should be healthy in order for us to perform at our best. We believe in combining elements of many areas, including but not limited to conventional or Western medicine, new methods backed by scientific research, and even holistic approaches such as ancient or Eastern medicine.

Many factors cause pain and imbalance in the body, including but not limited to injury, inflammation, bacteria, viruses, emotions, digestion, anxiety, or poor diet. Every patient can respond differently to various therapies and treatments, which is why our office will closely monitor your progress and adjust your therapies as needed.

We cannot promise you a specific level of result as soon as you come see us. What we can promise you is that our medical providers will work with you in an integrative capacity to achieve your optimal health goals.

CONSENT TO TREATMENT

As a patient you have the right to be informed about your conditions and recommended care. This disclosure is to help you become better informed so you may make the decision to give or withhold your consent as to whether or not to undergo care, having had the opportunity to discuss potential benefits, risks, and hazards involved.

Taking time for an individualized approach ensures that treatment plans are evidence-based, safe and custom-designed to meet the patient's needs and goals. It is important for you to know that the evidence for Orthobiologic and Neuromusculoskeletal Medicine changes frequently and that recommendations given to you are done with the evidence available at that time for your particular condition, and that evidence and recommendations can change over time. We will never recommend stopping conventional Western medical care or treatment.

You understand that the U.S Food and Drug Administration, or other institutions which regulate medications, has not fully evaluated or approved certain procedures or recommendations our providers may recommend, such as nutritional, herbal, and homeopathic supplements, orthobiologic injections, or various injections for non-surgical orthopedics; however, they have been widely used in Europe and the U.S for years. You understand that, as with drugs, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to

certain pre-existing conditions. You do not expect the medical provider to be able to anticipate and explain all risks and complications, and you wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment that the medical provider feels at the time, based on the facts then known, is in your best interest. You understand that if you do not take the supplements or treatments as recommended, you may not get the desired result or may increase chances for an adverse effect.

It is your responsibility to keep your medical provider up to date with all of the current medications and supplements that you are taking, so that he/she can make the best-informed recommendations for your care. You have the opportunity to ask questions and discuss with your provider to your satisfaction:

· Your suspected diagnosis or condition;
· the nature, purpose, and potential benefit of the proposed care;
· the inherited risks, complications, potential hazards, or side effects of the treatment or procedure;
· the probability or likelihood, of success;
· reasonable available alternatives to the proposed treatment or procedure;
· the possible consequences if treatment or advise is not followed and/or nothing is done.

You understand that the medical providers at Asheville Non-Surgical Orthopedics, PLLC have been trained in a diverse range of diagnostic and treatment options. You understand that Orthobiologic and Neuromusculoskeletal Medicine is highly specialized and based upon evidence-based medicine and is also based on holistic principles. As such, our providers may recommend different tests, may interpret tests differently, may propose different treatments, or may administer standard treatments differently than most conventional physicians. As many perspectives exist in medicine, in some cases there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care, lacking evidence, or medically unnecessary. Diagnosis and treatment may include some services that are considered non-traditional, nonconventional, or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental, investigational, or outside of your plan. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence-based medicine.

I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risks of injury and even death.

By signing this form, you acknowledge that you have carefully read, or have had read to you, and understand the above consent. You give your permission and consent to care and authorize medical treatment by Asheville Non-Surgical Orthopedics, PLLC, and their staff, and you are fully aware of what you are signing. You intend this consent form to cover the entire course of treatment for your present condition and for any future condition(s) for which you seek treatment, and you may ask your physician for a more detailed explanation or to answer any questions you may have. You intend this Consent to cover all forms of medical care given by Asheville Non-Surgical Orthopedics, PLLC, including but not limited to treatments that are considered outside the standard of care, such as alternative medicine or orthobiologic medicine.

FREQUENCY AND DURATION OF VISITS

Orthobiologic and Neuromusculoskeletal Medicine can require a significant amount of time for interaction between you and your provider. Some of this time will be used in assessing your medical history, as well as your background; some of this time will be used in assessing your medical or wellness needs and planning your personalized treatment plans; and some of this time may be used for taking lab samples or performing ultrasound imaging.

At your initial visit, we will decide together the structure of your therapy. If medications are prescribed, or changed, we may request a follow up visit in a few week's time. This is necessary to ensure proper administration and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at longer intervals. Labs may be drawn at your visits. For clients on maintenance therapy, follow-up visits can be held at different intervals. We may discuss an alternate treatment structure depending on your circumstances.

NOT A SUBSTITUTE FOR YOUR PRIMARY CARE PROVIDER

Please note that we do not recommend that you stop or discontinue seeing your primary care provider, or any specialists who may be currently treating you. We require that you maintain a primary care doctor for general medical needs including but not limited to your annual physical exam, Pap smear, prostate exam, or emergencies.

While our office does provide some acute care services, our providers are not specialists and may not have the equipment or ability to treat complex medical conditions. We are happy to work with you closely as a consultant and coach in preventive, nutritional, and integrative medicine to help you address the roots of chronic health problems. We are also happy to confer with your primary care doctor if desired

FEES

By coming to Asheville Non-Surgical Orthopedics, PLLC, you acknowledge, agree, and consent to pay any and all fees for the services provided by our office. Our staff or physician will provide you with the rates and fees for any of the services you request or that the physician recommends prior to charging you. Certain services may be covered by your insurance provider, while some services may not. Your physician or our staff can assist you in determining which services are eligible or covered by your insurance provider. If a service is not covered by your insurance, you acknowledge, agree, and consent to making full payment for the services out of pocket.

Fees may be subject to change. If our fees are to increase, we will provide you with a thirty (30) day notice to alert you to the change.

CANCELLATIONS, LATE ARRIVALS, AND NO-SHOWS

If you must cancel or reschedule an appointment, we require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment may be charged the full fee for the session or a cancellation fee.

Our office is committed to being on time with patients' appointments in order to prevent patients from waiting. If you arrive late to the office for your appointment, your appointment may still end at the scheduled time, and you may be charged for the length of the originally scheduled visit.

PAYMENTS

Our office requires payment prior to each visit. We accept cash, debit cards, and major credit cards. If payment is sixty (60) days past due, we reserve the right to utilize legal resources such as collection agencies or small claims court in order to obtain payment for our services. If legal resources are required to obtain payment, you agree that you will reimburse Asheville Non-Surgical Orthopedics, PLLC for these additional expenses.

INSURANCE POLICIES

Asheville Non-Surgical Orthopedics, PLLC does not currently accept insurance policies, including government plans such as Medicare or Medicaid for services including but not limited to osteopathic manipulations, musculoskeletal injections, nerve blocks, trigger point injections, and certain laboratory services. This also includes services which are generally not covered by these insurance or government policies, including but not limited to orthobiologic medicine, certain laboratory services, supplements, and acupuncture

If you wish to be reimbursed for your visits, labs, or medications, you will need to consult your insurance company to determine their policies regarding your benefits. You understand and agree to be fully responsible for the payment of all costs incurred for your treatment at Asheville Non-Surgical Orthopedics, PLLC including but not limited to visits, procedures, and treatments which are not covered by your insurance or government policy.

MEDICAL RECORDS

Our office is required by law to keep complete medical records. Most medical records will be electronic, encrypted, and under strict security.

Medical records can only be released with your authorization. If you wish for our providers to review your previous medical records, it is your responsibility to obtain previous medical records from your other physicians, or health care providers and provide them to our office. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least one week prior to your initial appointment.

CONFIDENTIALITY

The security of your sensitive information is of the utmost importance, and we are bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. There are exceptions to this confidentiality, where disclosure is mandatory. These may include but are not limited to the following:

· If there is a threat to the safety of others, our providers may be required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.

· When there is a threat of harm to yourself, our providers are required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.

· In legal hearings, subject to your right to refuse.

· In situations where a dementing illness, epilepsy, or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, our provider may be required to report this to the DMV.

· If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, our provider will be required to disclose information to seek hospitalization or assistance.

· These situations rarely occur in an outpatient setting. If they do arise, our providers will do their best to discuss the situation with you before taking action. In rare circumstances, our providers may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

OUR PRACTICE

You agree to follow all rules and requirements for the safe and legal use of controlled or prescribed medications, as prescribed by our providers or another physician. You also agree to follow all rules of the practice regarding behavior and safety. If your behavior is deemed to be inappropriate, aggressive, or outside the scope of a professional physician-patient relationship, we reserve the right to terminate your treatment and refer you to an appropriate physician or hospital for further treatment. In such an event, we will provide you with appropriate notice and make your medical records reasonably available to you as described herein.

OFFICE HOURS

Our office hours at our Asheville, NC location are currently:

Monday 9 am - 4 pm

Tuesday 9 am - 4 pm

Our office hours at our Coral Springs, FL location are currently:

Friday 4 pm - 10 pm

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of services, session structure, fees, cancellation/no-show policies, payment policy, insurance policies, confidentiality, the nature of Asheville Non-Surgical Orthopedics, PLLC's practice, and that you agree to abide by the terms stated above during the course of your treatment.

Patient name (please print): _____ Date: _____

Patient signature: _____

Signature of Parent/Legal Guardian if under 18: _____

Relationship to Patient: _____

Physician signature: _____ Date: _____