COASTAL INTEGRATIVE HEALTH

New Patient Case History/Information

Date: _____/_____/____

Patients Full Name: _____I prefer to be called: _____

Date of Birth: _____/_____/_____ Social Security #:_____ Marital Status: S M D W Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell: _____Work Number:_____

Email: _____

Occupation: _____ Hours/week: _____

Emergency Contact: _____Relationship: _____

Phone: _____

How were you referred to our office? _____

Is Today's Visit Due to a Work's Compensation Injury: Yes _____ No _____

Is Today's Visit Due to a Personal Injury or Auto Accident case: Yes _____ No _____

Primary Care Physician: _____Referring Physician(if applicable):_____

Primary Insurance Company: _____

Secondary Insurance Company (if applicable): _____

Policy Holder Name: _____Policy Holder DOB: _____ Relationship:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Doctors of Coastal Integrative Health, and/or In Motion Physical Therapy. I authorize the doctor(s) to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic/physical therapy care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you before signing this consent. The following person(s) have my permission to receive my personal information:

_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Name: _____

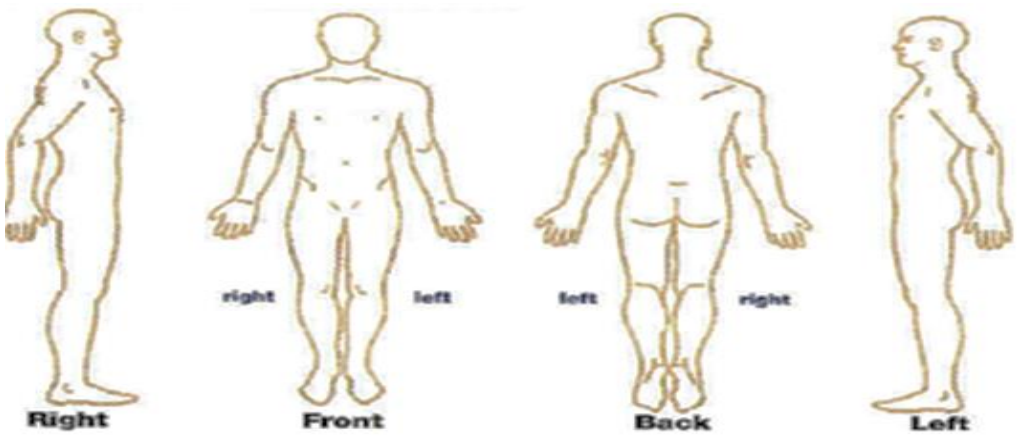
Reason for today's visit:

Emergency___ New injury___ Old injury___ Chronic Pain___ Wellness___ Physical Therapy___

Are you in pain: Yes No Rate your pain with the following scale:

Discomfort 1 2 3 4 5 6 7 8 9 10 intense

Using the body charts, please circle all affected areas:



Have you been treated by a Medical Physician for this condition? Yes____ No____

If so, where? _____

Have you ever been treated by a Chiropractor? Yes____ No____

Clinic or Dr's name: _____

Health History

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	**Y N** Heart surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Mitral Valve prolapsed	**Y N** Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease
Y N Hepatitis	**Y N** HIV+ /AIDS/ARC	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia/Diabetes	**Y N** High Blood Pressure
Y N Low Blood Pressure	**Y N** Rheumatic Fever	**Y N** Severe/ Frequent Headaches	**Y N** Kidney Disease
Y N Ulcers / Colitis	**Y N** Fainting/seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/ Asthma
Y N Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems
Y N Psychiatric Problems	**Y N** Arthritis	**Y N** Artificial Bones/Joints/Implants	

*Females Only: Are you or could you be pregnant? Yes____No___

Patient Name:_____

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	
Hernia	Other _____		

Please list all current medications being taken:

_____
_____
_____
_____
_____

Please list all vitamins, minerals, supplements or herbs being taken:

_____
_____
_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____	Vigorous Exercise	_____	Family Pressures
_____	Moderate Exercise	_____	Financial Pressures
_____	Alcohol Use	_____	Other Mental Stresses
_____	Drug Use	_____	Other (specify) _____
_____	Tobacco Use	_____	
_____	Caffeine	_____	
_____	High Stress Activity		

I certify the information provided is accurate to the best of my knowledge:

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____

COASTAL INTEGRATIVE HEALTH

One Patient, Multiple Solutions

728 Village Rd. SW
Shallotte, NC 28470
(910) 755-5400
(910) 755-5402 fax
www.coastalhealthnc.com

1175 Turlington Ave, Ste 103
Leland, NC 28451
(910) 408-1778
(910) 408-1759 fax

Physical Therapy Consent Form

I hereby request and consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. Your therapist will explain your physical therapy diagnosis and discuss treatment recommendations with you. Physical therapy as any other type of medical care is most effective if you participate according to the plan of treatment agreed upon with your therapist. If at any time you have questions concerning the type of services delivered or how your services are rendered, please talk with your therapist. Remember, we are here to provide you with the best care available in order to improve the quality of life through physical therapy.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, acknowledge my understanding of its contents.

Date: _____

_____
Patient Name

_____
Patient Signature

_____
Relationship or authority if not signed by patient

COASTAL INTEGRATIVE HEALTH

Cancellation Policy / No Show Policy
For Doctors Appointments and Procedures

Thank you for trusting Coastal Integrative Health with your healthcare needs. When you set an appointment with Coastal Integrative Health, we set aside enough time to provide you with the highest quality care. Should you need to cancel, or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule another patient who may be waiting for much needed treatment.

Established Patients:

- Effective January 3, 2023, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a **$30.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a **second consecutive** time will be charged a **$50.00 fee.**
- If a third consecutive No Show or cancellation/reschedule without a 24-hour notice should occur the patient may be dismissed from Coastal Integrative Health and will be billed **$75.00.**
- The fee is charged to the patient, not the insurance company, and is due at the time of the patients next office visit or as billed in our monthly statements.
- As a courtesy to you, we have appointment reminder systems in place to help avoid scheduling conflicts. As always, it is up to you to remember your appointment and cancel within 24 hours if needed.

New Patients:

- New Patient appointments block off a considerable amount of time on our providers schedules for proper evaluation. When there is a cancellation without 24-hour notice, this restricts the possibility of another patient receiving the care they need due to our books being "full."
- Any new patient who fails to show or cancels/reschedules an appointment without a 24-hour notice will be charged a **$50.00 fee.**
- If the new patient fails to show or cancels/reschedules an appointment a **second consecutive** time, the patient will be charged a **$75.00 fee.**
- If a **third consecutive** no show or cancellation/reschedule without 24-hr notice occurs, the patient may be dismissed from Coastal Integrative Health and will be billed **$100.00.**

_____ _____ _____/_____/_____

Patient Name (Print) **Signature** **Date**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the family members allowed: (use back of form for additional names)

Name:_____Relationship:_____

Name:_____Relationship:_____

This consent was signed by: _____(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

728 Village Rd, SW, Shallotte, NC 28470 www.coastalhealthnc.com
(910)755-5400
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COASTAL INTEGRATIVE HEALTH

Electronic Health Records Intake Form

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

Email address: _____

Preferred method of communication for patient reminders *(Circle one): Email / Phone / Text / Mail*

DOB: __/__/____ ***Gender (Circle one):*** *Male / Female* ***Preferred Language:*** _____

Smoking Status (Circle one): *Everyday Smoker/ Occasional Smoker/ Former Smoker/ Never Smoked*

CMS requires providers to report both race and ethnicity

Race (Circle one): *American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer*

Ethnicity (Circle one): *Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer*

Are you currently taking any medications? *(Please include regularly used over the counter medications)*

Medication Name/ Dosage/ Frequency	***Medication Name/ Dosage/ Frequency***	***Medication Name/ Dosage/ Frequency***

Do you have any medication allergies?

Medication Name	*Reaction*	*Onset Date*	*Additional Comments*

□ ***I choose to decline receipt of my clinical summary after every visit*** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ *Date:*_____

For office use only

Height: _____ *Weight:*_____ *Blood Pressure:*_____ /_____ *Foot Scan:* _____

*Initials:*_____/_____