Wellspring
HEALTH & SPORTS PERFORMANCE

Name: _____ Nickname:_____ SS#_____

Birthdate:____/____/_____ Age: _____ Sex: M__ F__ Martial Status: S___ M___ W___ D___

Phone:(H)_____ (W)_____ (Cell)_____ Email:_____

Address: _____ Apt:#_____

City: _____ State:_____ Zip: _____

Employer: _____ Position: _____

Spouse: _____ Spouse DOB: ___/___/_____ Spouse Employer: _____

Children (Names & Ages): _____

Emergency Contact: (Name/Relation)_____ (Number)_____

Primary Care Physician:_____ Did s/he refer you? Yes___ No___

How did you hear about our office? _____

Insurance Company Name: _____ Insured DOB: ___/___/____

Insured's Employer: _____ Insured's SS#:_____

Assignment of Insurance Benefits:
I assign the payment of benefits due to me under my insurance policy with my carrier, and my direct insurance carrier to pay for all services rendered directly to Wellspring Health and Sports Performance.

Release of Medical Information to Insurance Carrier:
I give permission to Wellspring Health and Sports Performance to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims.

Informed Consent Agreement:
If I do not understand the necessity for, or the risk of, any therapy of manipulative procedure used in my care, I may request an explanation before performed so that I may give informed consent or objection.

Consent to treat a Minor: (if applicable)
I hereby authorize Dr. Kampfe and his assistants to administer the medically necessary chiropractic care and therapy, as they deem necessary, and without my presence when necessary, to the above names patient, my _____ (relationship to minor).
I sign here for consent to treat my minor: _____

****All the above and following confidential health information has been read and is completed as true by the below signed individual who is responsible for the answering of these statements and the balance of payments on these accounts:**

Signature: _____ Date: _____

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1. What is your major complaint?_____
2. What caused this problem? _____
3. When did your major complain start? _____
4. Describe the pain: Sharp:____ Dull:____ Numbness:____ Tingling:____ Aching:____ Itchy:____ Burning:____ Stabbing:____ Other:_____
5. How frequent is the condition? Constant:____ Intermittent:____ Night Only:____ Day Only:____
6. How long does it last? All Day:____ Few Hours:____ Minutes:____ Seconds:____
7. What makes the problem worse? Standing:____ Sitting:____ Lying:____ Bending:____ Breathing:____ Twisting:____ Lifting:____ Sleeping:____
   Other:_____
8. Is there anything you can do to relieve the problem? Yes____ No____
   If yes, please describe: _____
9. Has any doctor recently treated you for this condition? Yes___ No___ In the past? Yes___ No___
   Doctor:_____ When:_____
   Any (check all that apply): X-Rays:___ MRI:___ Medication:___ Injections:___
   Other:_____
   Results: None:___ Fair:___ Good:___ Worse:___ Other:_____
10. Is this a recurrence? Yes___ No___ If yes, when did you first notice the problem?_____
11. Are there any other conditions or symptoms you have that may be related to your major symptom? (Circle One) Yes No If yes, please describe:_____
12. List medications taken within the last 7 days: _____
13. Last blood work date: _____ Physician Ordering: _____
14. List ALL allergies: _____
15. Have you had any chiropractic or muscle therapy for this condition in the past? Yes___ No___
16. Did you find your prior treatments and experiences helpful? Yes___ No___
    Doctor: _____ Treated from:_____ to:_____
    What conditions were treated?_____
17. Have you had Acupuncture treatments, Neuromuscular therapy, Herbal or Vitamin therapies ever? If yes, please comment: _____
18. Any changes in your special senses lately? Circle the sense(s) in which you have noticed a change.
    Smell Taste Touch Hearing Vision Balance Equilibrium
19. Has your thyroid gland been tested in past year? No___ Yes____ Date of last test:_____

Patient's Name: _____ **Date:_____**

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System Review: (Please check all which have applied to you in the past year)

__Recurring headaches/migraine
__Dizziness/loss of balance/fainting
__Eye pain/temple pain/face pain
__Jaw pain/TMJ problems/swallowing
__Forgetfulness/confusion/disorientation
__Visual disturbances/blurry vision/double vision
__Ear noises/hearing loss
__Nausea/vomiting/vertigo
__Restricted movement-neck
__Pain around collar bone/front of neck
__Problems sitting/lying/bending/standing
__Pain/numbness/tingling into arms/hands
__Pain/numbness/tingling into legs/feet
__Problem rolling over/getting up and down
__Bowel problems: constipation/diarrhea
__Chest/ribcage pain/tightness/pressure
__Shoulder pain/dysfunction
__Difficulty breathing/painful breathing
__Problems sleeping due to pain
__Unexplained fatigue/loss of focus
__Low back pain/soreness/stiffness
__Hurts to cough/sneeze/move bowels
__Buttocks/hip/tailbone pain
__Other pain/numbness/tingling
__Loss of muscle strength
__Swollen feet, ankles, or legs
__Pain between/under shoulder blades
__Problems walking: limp, drag foot
__Arthritis/stiff joints
__Knee, feet, or ankle pain
__Changes – urinary habits: more/less
__Frequent/painful/burning urine
__Drug reactions
__Other "new" pain_____

Significant Illness: (Check all that apply)

__Heart trouble
__Cancer
__Mental/Depression
__Tuberculosis
__Seizures/Stroke/TIA
__Thyroid problems
__Drugs/Alcohol
__Liver/Kidney/Spleen
__High blood pressure
__Diabetes
__Arthritis
__Colon/Stomach problems
__Blood clots/Embolism
__Asthma/Lung Disease
__HIV positive
__Other_____

Surgical Procedures: (Check all that apply and write the year next to it)

__Appendectomy
__Breast/Implants
__Eye/Ear/Nose
__Heart/Lung
__Neck/Back
__Carpal Tunnel
__Done Fusions
__Prostate
__Stomach/Pancreas
__Brain
__Hysterectomy/D&C/Tubal
__Gallbladder
__Hernia
__Other_____
__Hip/Knee/Ankle/Foot
__Nerve
__Kidney
__Vasectomy/Artery/Vein
__Vascular
__Shoulder/Elbow

Have you ever been given a permanent impairment rating? No___ Yes___

Patient Name: _____ Date:_____

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Accident/Injuries:

	Describe Injury	Age
Falls	_____	_____
Sports	_____	_____
Auto Accidents	_____	_____
Other	_____	_____

Medications: (circle for current conditions)

1. Over the counter: Advil Afin Aleve Aspirin Benadryl Coldese Excedrin Goody's Midol Tylenol Others_____

2. Prescriptions – list all prescription drugs, antibiotics used and why you are taking them/who prescribed them:_____
_____

Nutritional Profile Continued.

1. Has your weight changed more than 10lbs in the past year? N:___ Y:____ , _____#lbs.
2. Number of times you exercise each week: _____, for _____#minutes average.
3. Number of hours you sleep (average): _____ . How many times do you wake up? _____.
   Dreams: Y:__ N:__ . What time do you go to bed?_____ . How long do until asleep?_____.
   What time do you wake up?_____

Stress-Relaxation Profile:

Circle all stresses:	Co-Worker	Boss	Financial	Home
	Friend	Child	Parent	Spouse
	Ex-Spouse	Pain	Emotional	Mental-Health Issues
	Personal-Health	Work too much		

Circle all relaxation methods:	Sleep	TV	Read	Music	Alcohol	Smoking
	Drugs	Eating	Walking	Jog	Run	Swim
	Prayer	Meditate	Centering	Solitude	Deep Breathing	Quietness

Patient's Name: _____ **Date:_____**

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Family History: Review the disease categories and use the appropriate letter(s):
GP(grandparent) **F**(father) **M**(mother) **B**(brother) **S**(sister) **C**(child)

Aneurysms_____
Arthritis_____
Asthma_____
Alzheimer's_____
Cancer_____
Diabetes_____
Polio_____
Blood Clots_____
Stomach/Pancreas_____
Headaches_____
Heart Attack_____
Thyroid_____

Stroke/TIA_____
Kidney/Liver_____
Low back pain_____
Mental illness/Depression_____
Migraines_____
Multiple Sclerosis_____
Disc Degeneration_____
Emphysema/Lung_____
Epilepsy/Parkinson's_____
Sinus Infections_____
High Blood Pressure_____
Tuberculosis _____

For Women Only: Are you pregnant? N:__ Y:__ . Any chance that you are pregnant? N:__ Y:__ .

Do you use birth control? N:__ Y:__ . If yes, please circle: Pills Condoms Shots Diaphragm Herbs
Endometriosis Tubal Hysterectomy Vasectomy

Beginning date of last menstrual cycle:_____. Do you have painful periods? N:__ Y:__

I,_____ (print name), affirm that the above pages are true and complete.

Patient Signature:_____ Date:_____

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Notice of Privacy Practices Acknowledgement Form

I acknowledge that Wellspring Health and Sports Performance (otherwise known as "the Center") has provided me with a copy of its Notice of Privacy Practices. I understand this acknowledgement means only that I have received the notice, and in no way affects the care I receive.

I understand that the Center will contact me at home either via phone or postcard and that it is my responsibility to notify the office should I choose not to be contacted for appointment reminders.

I understand that the Center may contact me for purposes of providing information regarding treatment alternatives, services or goods and that it is my responsibility to notify the office should I choose not to be contacted regarding treatment alternatives, services or goods.

I understand that the Center utilizes a color pain diagram as my treatment sign-in. I understand that should I choose for other patients not to see my patient information that it is my responsibility to hold onto the sign-in page until it is requested.

I understand that the initial examinations are completed in total privacy, but that routine chiropractic treatment is rendered in a semi-privately designed room.

_____ _____

Print Name Date

_____ _____

Patient's Signature Relationship to patient (if not patient)

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Client Statement

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health. This is considered a personal ministry and spiritual counseling.

I fully understand that those who counsel me are not medical doctors and I am not seeking advice for medical – diagnostic purposes of treatment procedures. I am not on this visit/phone consultation, or any subsequent visit/phone consultation, an agent for federal, state or local agencies, or on a mission of entrapment or investigation.

The services performed by Eileen Kampfe or others are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing or prescribing of remedies for the treatment of disease.

Signature:_____ **Date:**_____

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Financial Policy Statement

Dear Patient:
We appreciate your decision to select our office for your healthcare needs. Our main concern is you and that you understand your condition and receive the proper care needed to restore your health. We hope that you understand that our financial policy is a necessary part of assuring the financial resources required in operating a professional healthcare facility for our community. Therefore, we have implemented the following financial policy. We ask that you read, agree and sign the financial policy prior to seeing a provider.

Payments for services are due at the time of service, unless prior arrangements have been made. We accept cash, check, and for your convenience, credit and debit cards. We will be happy to send your insurance claim to your carrier as long as you provide us with your current and accurate insurance information. Currently we participate with Blue Cross Blue Shield, Florida Blue, and Cigna. Some plans require a referral from your primary care physician and/or an authorization number for your insurance company before we can render professional services under your policy. Correct identification of your policy will allow us to submit an accurate claim on your behalf. Maintenance care cannot be billed to a third-party insurance carrier. We must emphasize the following:

- Co-payments and deductibles are due at the time of service.
- If your plan requires a referral, you are required to obtain that referral prior to your appointment. If you do not obtain the referral, you (the patient) are responsible for payment in full at the time of service.
- Not all services are covered under the benefits of certain plans. Any charges not paid by the insurance companies are the responsibilities of the patient. Including Health Savings Accounts (HSAs).
- If your insurance does not pay in full within 45 days, we ask that you contact the customer service department of your insurance company to expedite payment to the center.
- If your insurance does not pay in full within 60 days, we require you to pay the balance due within 10 days of notice.
- We do not accept assignment on out of state policies that are not governed by the Florida Department of Insurance.
- We do not do secondary billing if you have a multiple policy benefits without an additional fee of $35 for filing.
- Returned checks are subject to a $50 return check fee to cover bookkeeping and bank expenses.
- All balances older than 90 days will be reviewed and turned over to an outside collection agency if payment arrangements have not been resolved.
- **If you miss a scheduled appointment without the proper 24-hour notice, we reserve the right to charge a fee of $50.**

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we can assist you in the management of your account. Again, thank you for choosing us for your health care needs, and we appreciate the opportunity to serve you.

I, _____(print name), have read the above policy and agree to its provisions.

Patient Signature_____ Date_____

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Records Release Authorization

To_____

Date_____ Phone_____ Fax_____

I, _____, do hereby declare that this request is made for the Continuation of Care with this Health Care Facility, staff and physicians. I request that you release any and all of the following medical records from my Confidential Health Files:
ER notes; History & Physical Exam notes; Treatment notes; Admission documentation/diagnosis; Plain film/CT/MR reports; Surgical notes; Lab reports; Path reports; Discharge Summary; Electro-diagnostic studies; Physical Therapy assessment, daily notes; discharge summary; or _____; to:

Wellspring Health and Sports Performance
Marcus A. Kampfe, DC
Eileen Kampfe, Master Herbalist
710 3rd Street North, Jacksonville Beach, Florida 32250
Phone: (904) 249-1551, Fax: (904) 249-1530

This authorization will expire in six months from above date unless otherwise specified here_____/_____(initials) and I may revoke this authorization at any time in writing.

✕_____ _____

Signature (Patient or Guardian) **Date of Birth**