Wellspring
HEALTH & SPORTS PERFORMANCE

Name: _____ Birthdate:____/____/_____ Age: _____ Sex: M__ F__

Martial Status: S___ M___ W___ D___ Phone:_____ Email:_____

Address: _____ Apt:#_____

City: _____ State:_____ Zip: _____

Employer: _____ Position: _____

Spouse: _____ Spouse DOB: ___/___/_____

Children (Names & Ages): _____

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

**Do you have a pacemaker or any heart conditions?** _____

_____

**Do you have any records that we need to request? Yes_____ No_____**

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

How did you hear about our office? _____

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

**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 or Dr. Jessica Bellinger 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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- What is your major complaint and when did it start: _____
  How long does it last? _____ How frequently does it occur? _____
- Is this a new complaint Yes____ No____ or, Have you noticed this in the past? Yes____ No____
- If yes, when did you first notice the problem? _____
- What caused this problem? _____
- Describe the pain: Sharp:____ Dull:____ Numbness:____ Tingling:____ Aching:____ Burning:____ Stabbing:____
  Other:_____
- What makes your complaint better or worse? _____

- Height: _____ Weight: _____
- Has any doctor treated you for this condition? Yes___ No___ Doctor: _____ When? _____
- Did you find your prior treatments helpful? Yes____ No____
- Have you had any chiropractic or muscle therapy for this condition in the past? Yes____ No____
- Any: X-Rays:___ MRI:___ Medication:___ Injections:___ ○ Other/
  Results:_____

- Have you ever been given a permanent impairment rating? No___ Yes___
- Are there any conditions you have that may be related to your complaint? Yes___ No___
- If yes, please describe:_____

**Accident/Injuries:**

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

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

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

# Nutritional Profile

**Medications:**

**List ALL prescription drugs, supplements, antibiotics, over the counter used and why you are taking them/who prescribed**:_____

_____

**Have you ever had any surgeries?** No___ Yes___

Please Describe:_____

Has your weight changed more than 10lbs in the past year? N: ___ Y: ____, _____#lbs.

Number of times you exercise each week: _____, for _____#minutes average.

Hours you sleep (average): _____ How many times do you wake up? _____ Dreams: Y: __ N: __

What time do you go to bed? _____ How long until asleep? _____ What time do you wake up? _____

**List any stressors/relaxation methods you have:** _____

List Vaccinations: _____

Last blood work date: _____Physician Ordering: _____

**List ALL Allergies:** _____

Have you ever had any of the following therapies: Acupuncture, Neuromuscular, Herbal, Vitamin? If yes, Please list:

_____

Have you had any changes in Smell, Taste, Touch, Hearing, Vision, Balance, and Equilibrium lately? _____

Has your thyroid gland been tested in the past year? _____ Date of last test: _____

**For Women Only**:

Are you pregnant? Y:___ N:___ Any chance that you are pregnant? Y:___ N:___ Do you use birth control? Y:__ N:__

If yes, please circle: Pills Condoms Shots Diaphragm Herbs Endometriosis Tubal Hysterectomy

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

**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_____ | Stroke/TIA/Blood Clots_____ | Epilepsy/Parkinson's_____ |
| Arthritis_____ | Kidney/Liver_____ | Emphysema/Lung_____ |
| Asthma_____ | Polio_____ | Heart Attack_____ |
| Alzheimer's_____ | Mental illness/Depression_____ | Thyroid_____ |
| Cancer_____ | Stomach/Pancreas_____ | Sinus Infections_____ |
| Diabetes_____ | Multiple Sclerosis_____ | High Blood Pressure_____ |
| Headaches/migraines_____ | Disc Degeneration_____ | Tuberculosis _____ |

**Significant Illness:** (Check all that apply)

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

## Notice of Privacy Practices Acknowledgement Form

I acknowledge that Wellspring Health and Sports Performance 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 Wellspring will contact me at home via phone or postcard regarding appointment reminders, information on treatment alternatives, services or goods and that it is my responsibility to notify the office should I choose not to be contacted regarding this.

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

## 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 or diagnostic purposes of treatment procedures. I am not on this visit/phone consultation, or any subsequent visit/phone consultation with 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.

## Financial Policy Statement

We appreciate your decision to select our office for your healthcare needs.

Our goal is that you receive proper care needed to restore your health and ensure that you understand your condition. We hope that you understand our financial policy is a necessary part of operating a professional healthcare facility for our community. We have implemented the following financial policy and we ask that you read, agree and sign 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, credit and debit cards. We will send your insurance claim to your carrier as long as you provide us with your current insurance information. Currently we participate with Blue Cross Blue Shield, Florida Blue, and Cigna. Some plans require a referral/authorization from your primary care physician 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.

- **Co-payments and deductibles are due at the time of service.**
- **If you miss a scheduled appointment without 24-hour notice, we reserve the right to charge the cost of the visit.**
- **Balances:** Not all services are covered under 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 your insurance company to expedite payment. If your insurance does not pay in full within 60 days, we require you to pay the balance due within 10 days of notice. 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 your plan requires a referral, you are required to obtain that referral prior to your appointment. If you do not obtain the referral, you are responsible for payment in full at the time of service.
- 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.

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. 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 policies and agree to its provisions.

Patient Signature _____ Date _____