

Apex Physical Medicine

3684 Dressler Rd NW Unit 2B Canton, OH 44718

Patient Name _____ Date: _____ ☐ Male ☐ Female

Email: _____ SS #/SIN _____ DOB _____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home phone _____ Cell Phone _____

Patient's Address _____ City _____ State _____ Zip _____

Employer Name: _____

Spouse or Patient's Guardian name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent or Guardian Signature

Date

Responsible Party

Name of The Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured _____ Relationship to patient _____ Birthdate _____

SS #/SIN _____ Name of Employer _____ Work Phone _____

Address of Employer _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Please print name and relationship for each person to whom you are authorizing released of your private health care information and account balances

NAME

Relationship

Signature of the Patient, Parent or Guardian

Date

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle “yes” or “no”/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES	Hepatitis.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES	Ulcer.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES	Kidney Disease.....	NO	YES
Whooping Cough....	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES	Thyroid Disease.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray_____			Bleeding Tendency.....	NO	YES
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES	Any Other Disease.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES	(Please List):		
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES	_____		
Rheumatic Fever.....	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES	_____		
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES	_____		
Venereal Disease.....	NO	YES	Blood or Plasma			Mitral Valve Prolapses.....	NO	YES	_____		
			Transfusion.....	NO	YES	Stroke.....	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

CLINICIAN SIGNATURE: _____ DATE REVIEWED: _____

PATIENT NAME: _____ DATE: _____

Name: _____ DOB _____ Date: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		Muscular/Skeletal	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		General	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

List your Health Goals in order of importance:

1. _____
2. _____
3. _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor’s office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent or Guardian

Date

Doctor’s Review

Signature of Doctor

Date

PATIENT CONSENT FOR COMMUNICATION

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience with in our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from APEX Physical Medicine. _____ (initial)

2. I consent to receive text messages from APEX Physical Medicine at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is:

_____ Carrier: _____ (initial)

3. I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is: _____ (initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. _____ (Initial)

Signature: _____ Date: _____

PATIENT CONSENT TO TREAT:

I hereby authorize the Doctor's/Nurse Practitioners' of APEX Physical Medicine to treat my case as they deem appropriate through the use of lab testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing. I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves.

Signature: _____ Date: _____

Missed Appointment Policy

We realize that things may come up and appointments may be missed. However, we block off the appropriate amount of time for each patient that may not be filled without advanced notice. Therefore, there is a \$25.00 charge for missed appointments without a 24-hour notice. This charge is the your, responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments. Patients who frequently miss appointments without 24 hours notice may be required to make a deposit to hold future appointments.

If multiple appointments are missed without notification, we may recommend that you seek treatment at another facility. If continued treatment is requested in our office after multiple missed appointments, we will require signed authorization to charge any and all missed appointments to a credit card, which we keep on file. In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

Signature: _____ Date: _____

Authorization to Release Records to my Family Physician or Specialist

I _____ authorize Dr. Brandon Blood, DC/Megan Leadbetter, APRN/
Dr. Nathan Bukuts, DC/ Dr. Eugene Mennow, DC/ Dr. Matthew Noyes MD, PT to release my records
from APEX Physical Medicine to _____, my Family Physician as well as to
_____, the Specialist that I have seen for my condition (if applicable).

Name: _____ Signature: _____

Authorization for Release of Medical Information

I _____ request and authorize _____ to release
_____ records to help them in determining my care.

Please Fax Records ATTN to: Apex Physical Medicine

Fax Number: (330) 479-9165

Patient Signature: _____ Date of Birth: _____

Social Security Number: _____

Dr. Brandon Blood, DC
Dr. Nathan Bukuts, DC
Dr. Eugene Mennow, DC
Megan Leadbetter, APRN
Dr. Jim Franz, DO
Matthew Noyes, MD, PT
3684 Dressler Rd NW Unit 2B
Canton, OH 44718
(330) 479-9193
Fax (330) 479-9165

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS
MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Dr. Brandon Blood Apex Physical Medicine as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____. X_____ (SEAL)

(patient signature)

X_____ (SEAL)

(Guardian if applicable)

X_____

(Printed Name of Patient)

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Provider" refers to Dr. Brandon Blood, DC, Dr. Nathan Bukuts, DC, Dr. Eugene Mennow, DC, Dr. James Franz, DO, Dr. Matthew Noyes MD, PT, Megan Leadbetter, APRN or APEX Physical Medicine.

I consent to the use or disclosure of my protected health information by the Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that analysis, diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Providers not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider.

I have the right to revoke this consent, in writing, at any time, except that the Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also posted in the waiting room at APEX Physical Medicine. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

The Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name: _____

Signature: _____