Aligned Medical Group, P.C.

PROVEN CARE. HEALTHY LIVES.

49 E. Lancaster Ave., Ste. 100, Malvern, PA 19355
P: 610-644-3166 F: 484-203-3013

PATIENT INFORMATION

Today's Date:_____

Name (First MI Last): _____ Preferred Name: _____

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

Preferred Phone Number: ☐ Home ☐ Cell ☐ Work

Address: _____Apt. # _____

City:_____ State:_____ Zip: _____

Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F Social Security Number: _____

E-Mail Address: _____ May we send you our monthly newsletter? Yes No

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed

How were you referred to our office:

☐ Doctor: _____ ☐ Friend/Family _____ ☐ Insurance

☐ Internet Search ☐ Facebook ☐ Advertisement_____ ☐ Other: _____

Employer or School: _____

Occupation: _____

Address:_____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed

☐ Retired ☐ Military ☐ Student

☐ Other:_____

Emergency Contact:_____ Relationship to Patient: _____

Address:_____ Phone number: _____

Primary Care Physician:_____ Phone number: _____

Address:_____

Preferred Pharmacy:_____ Phone number: _____

Address:_____

INSURANCE INFORMATION

We will request to scan your ID and insurance card

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Yes No

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Yes No

INSURED INFORMATION (IF OTHER THAN PATIENT)

Subscriber/ Policy Holder:_____

Relationship to Patient: _____

Address:_____

Date of Birth:_____

Social Security Number: _____

His or Her Employer:_____

Work Phone Number: _____

SYMPTOMS

Symptom 1: _____ Symptom 2: _____

(please fill out the remaining questions based upon your primary complaint)

Have you had this symptom before? ☐ No ☐ Yes

Current condition of symptom(s): ☐ improving ☐ aggravated ☐ Same ☐ Worsening

When did you first notice the symptoms?_____ How did it start? _____

Where is the problem(s) located? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Stabbing ☐ Pins/Needles

Rate the overall severity of your pain. (0 = no pain, 10 = severe pain): 0 1 2 3 4 5 6 7 8 9 10

How would you rate your overall posture? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you ever been in an automobile accident? ☐ No ☐ Yes Describe:_____

How often do you experience your symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% of the time.

Is this condition associated with a recent trauma/injury? ☐ No ☐ Yes Explain:_____

Which activities aggravate your condition? *(Please check all that apply)*

□ Bathing	□ Bending	□ Cleaning	□ Lifting	□ Yardwork	□ Housework
□ Cooking	□ Climbing Stairs	□ Dressing	□ Exercising	□ Gardening	□ Working
□ Jumping	□ Lying Down	□ Mowing	□ Playing Sports	□ Reading	□ Running
□ Sitting	□ Sitting at Computer	□ Sleeping	□ Squatting	□ Stand from Sitting	□ Standing
□ Turning	□ Twisting	□ Walking	□ Caring for Children		

What treatment(s) have you received for your condition? *(Please write date of last visit, provider name and details)*

☐ Physician Visit_____
☐ Medication/Injection _____
☐ Physical Therapy _____
☐ Chiropractic _____
☐ Acupuncture _____
☐ Nutritional _____
☐ Other _____

CERTIFICATION

To the best of my knowledge, the information provided in this packet is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health, at any time in the future.

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

HEALTH HISTORY

Name:_____ Date:_____

PERSONAL HISTORY:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Breathing Problems
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis/ Joint Replacement
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Typhoid Fever
- ☐ Tuberculosis
- ☐ Tumor, Growths
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Diseases
- ☐ Whooping Cough
- ☐ Other:_____

_____

FAMILY HISTORY:

	Mother	Father	Grandparents	Siblings
Alcohol/Drug Abuse	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Alzheimer's/Dementia	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Asthma	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Autoimmune Disease	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Blood Disorders	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Cancer	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Diabetes	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Heart Disease	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
High Cholesterol	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Hypertension	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Kidney Disease	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Lung Disease	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Mental Illness	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Migraine/Headaches	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Osteoporosis	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Respiratory Problems	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Rheumatoid Problems	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Seizures	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Stroke	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Thyroid Disease	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □
Other:	□	□	1. □ 2. □ 3. □ 4. □	1. □ 2. □ 3. □ 4. □

HEALTH HISTORY

LIST ALL ALLERGIES: _____

_____

_____

DAILY HABITS:

1. What is your current level of exercise? ☐ None ☐ Mild ☐ Moderate ☐ Heavy
2. Check types of exercise performed at least twice per week: ☐ Stretching ☐ Weight/resistance ☐ Yoga ☐ Pilates ☐ Core Exercise ☐ Walking ☐ Running ☐ Other Cardiovascular Exercise_____
3. What do your daily work habits include? ☐ sitting ☐ standing ☐ light labor ☐ heavy labor ☐ computer work ☐ driving ☐ walking ☐ other: _____
4. Do you have difficulty maintaining a healthy weight? ☐ No ☐ Yes
5. Do you /have you ever smoke(d) cigarettes? ☐ No ☐ Yes

   If yes, how many packs per day? _____ For how many years? _____ When did you quit? _____
6. How much liquor do you consume on a weekly basis?_____
7. Caffeine on a daily basis? _____

MEDICATIONS/SUPPLEMENTS:

List all medications you are currently taking and what you are taking them for:

(Please attach additional information if applicable)

Medication:	Dose/Strength:	For:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all surgeries, dates of surgery, Dr. that performed surgery: *(Please attach additional information if applicable)*

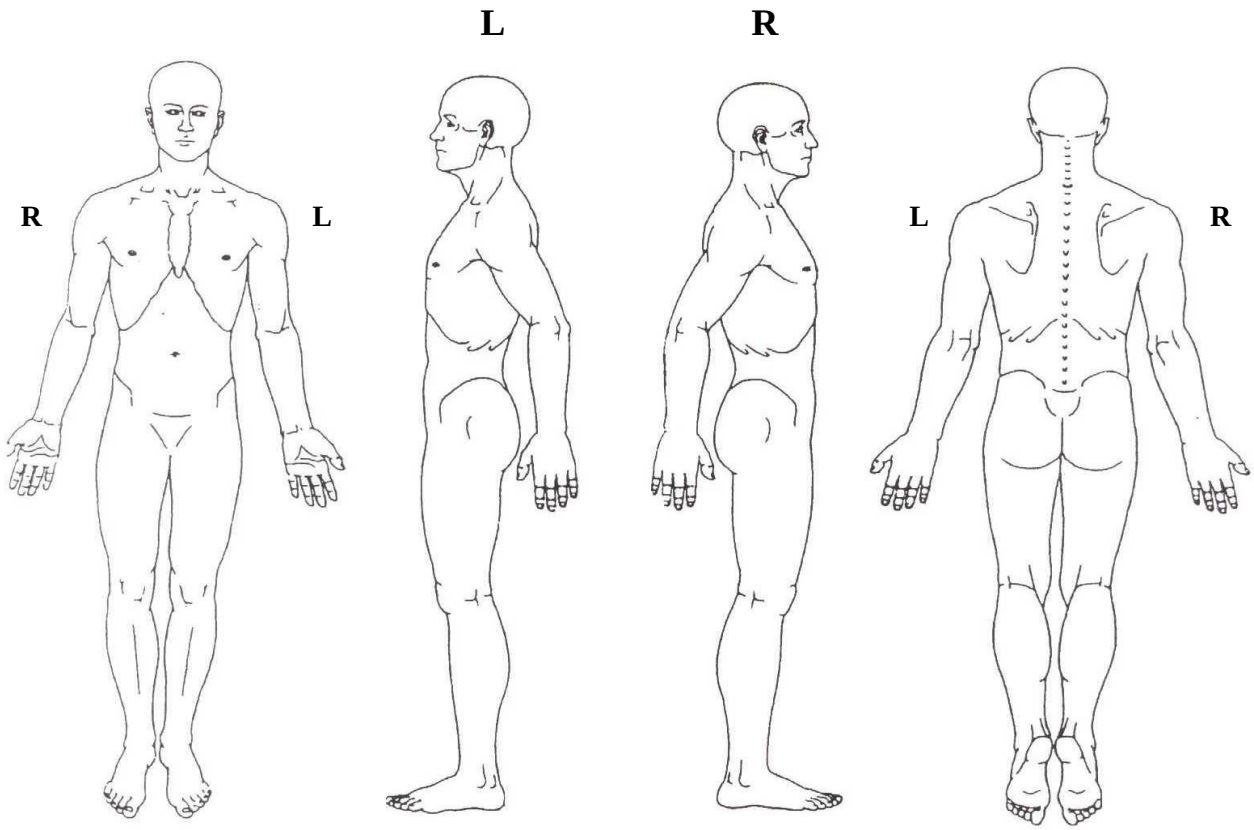
Surgery:	Date:	Dr. who performed surgery (or where):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Women: Are you pregnant? ☐ Yes ☐ No Trying to become pregnant? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

PAIN DRAWING

Using the following descriptive symbols, draw the location of your pain on body outlines below.

ACHE	BURNING	NUMBNESS	PINS & NEEDLE	STABBING	OTHER
/\/\/\/\	========	OOOOOOO	……	//////////	XXXXX
/\/\/\/\	========	OOOOOOO	……	//////////	XXXXX



Please make a slash on each line below indicating your pain level…

AT ITS WORST: No Pain ⟷ Worst Possible Pain

ON AVERAGE: No Pain ⟷ Worst Possible Pain

AT ITS BEST: No Pain ⟷ Worst Possible Pain

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

Aligned Medical
Group, P.C.
PROVEN CARE. HEALTHY LIVES.

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 Aligned Medical Group, P.C. 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 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.

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

PRIVACY PRACTICES and HIPAA ACKNOWLEDGEMENT

Aligned Medical Group, P.C.
49 E. Lancaster Ave., Ste. 100
Malvern, PA 19355
Telephone: (610) 644-3166

ACKNOWLEDGEMENT FORM

I have been provided an opportunity to review and have read the Notice of Privacy Practices.

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Date of Birth

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

NOTICE, CONSENT, AND RESTRICTION REQUESTS

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Date of Birth

As required by the **Health Portability Act of 1996,** Aligned Medical Group may not use or disclose your health information without your authorization. Your signature on this form indicates you are giving permission for the uses herein. You may revoke this authorization at any time.

SPECIFIC AUTHORIZATIONS

Please initial:

_____ I give my permission to Aligned Medical Group to use my address, phone number and clinical information to contact me, and or other physicians, and or my employer (if work related) with appointment changes, follow-up messages, test results, laboratory results, and/or, other related health information.

_____ If Aligned Medical Group contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail, or cellular phone.

_____ I give my permission to leave information about appointment times, test results, and/or other health information with the following people:

_____ _____

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

Aligned Medical Group, P.C.

PROVEN CARE. HEALTHY LIVES.

CANCELLATION POLICY

This policy is for appointments missed, rescheduled and cancelled. Aligned Medical Group requires 24 hours notice prior to cancelling or rescheduling appointments. There will be a $25 charge for missed appointments and for those cancelled with less than 24 hours notice. Late arrival for massage appointments may result in a reduction in your treatment time.

Cancellation fees for appointments will be donated to the Chester County SPCA. In the case of massage, cancellation fees will go directly to the massage therapist. We appreciate early notice of rescheduling or cancelling your appointment so we may offer your time slot to another patient.

My signature below indicates that I understand Aligned Medical Group's Cancellation Policy and my financial responsibilities.

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date