First Name
-

Last Name
-

Date of Birth
-

Today's Date
-

Age
-

Phone
-

Email
-

Address
-

City
-

State
-

Zip
-

Gender
☐ Female ☐ Male

Marital Status
☐ Single ☐ Divorced ☐ Widowed
☐ Married

Occupation
-

Emergency Contact First Name
-

Emergency Contact Last Name
-

Emergency Contact Phone Number
-

Emergency Contact Relationship
-

Please note: Pelvic Floor Occupational Therapy requires a script from an OB/GYN or MD. We will need this script before we can perform an evaluation and/or treatment. Scripts can be faxed to our office at 610-743-8494 or emailed to info@corehealthberks.com. They MUST say OCCUPATIONAL THERAPY or PELVIC FLOOR THERAPY. It will be your responsibility to make sure script is obtained and sent to us before your appointment.

Referring Provider
-

Current condition(s) that bring you in today
-

When did your symptoms begin
-

List any tests that have been performed and the results: (Xrays, MRI, CT scans, cystoscopy, labs)
-

Have you received other treatments for your current condition(s): PT, chiropractic, massage, acupuncture, medical intervention) Please list with your providers of care
-

Are you having pain associated with your symptoms

☐ Yes ☐ No

Please rate the severity of your pain

☐ 1 (no pain) ☐ 2 ☐ 3
☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9
☐ 10 (extreme pain)

Current/past medical history (check all that apply)

☐ anemia
☐ anxiety
☐ depression
☐ bladder/vaginal infections
☐ urinary frequency, hesitation, urgency
☐ high blood pressure
☐ low back pain
☐ pelvic pain
☐ urinary or fecal leakage/incontinence
☐ interstitial cystitis
☐ constipation, IBS, chronic diarrhea
☐ abdominal pain
☐ sexually transmitted diseases
☐ Pudental nerve irritation
☐ tailbone pain
☐ Hepatitis / HIV / AIDS
☐ smoking history or currently
☐ blood in urine
☐ Prostatitis
☐ heart problems
☐ pelvic organ prolapse
☐ chronic fatigue
☐ Fibromyalgia
☐ sleeping disorders
☐ anorexia / bulimia
☐ falls
☐ kidney disease
☐ vision/hearing problems
☐ Osteoporosis
☐ Endometriosis
☐ hemorrhoids
☐ fibroids
☐ cysts / polyps
☐ painful intercourse
☐ vaginal dryness
☐ hormonal problems
☐ trouble holding in gas
☐ trouble feeling bladder fullness
☐ dizziness/fainting
☐ headaches
☐ epilepsy/seizures
☐ diabetes
☐ breathing difficulties
☐ prostate cancer
☐ breast cancer
☐ ovarian/uterine cancer
☐ other cancer
☐ allergies

Other medical histories or concerns

-

Please list goals of yours for treatment

-

Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I hearby authorize payment to be made directly to Core Health Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Core Health Chiropractic for any and all services I receive at this office.

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time the claim is received. We will verify your benefits and outline them to you to the best of our knowledge. It is your responsibility to fully understand your insurance benefits. Payment is due at the time of treatment. I agree to pay Core Health Chiropractic all amounts that are due for services rendered, which includes deductible amounts, copays, and cash charges. We require a credit card to be kept on file to pay for these services.

Any applicable co-pay/deductible amount/cash rate is due at the time of service. Co-insurance, deductibles, and payments for non-covered services are the patient's responsibility. An itemized statement will be sent to you after your insurance company has processed your claim. We do require that a credit card be kept on file for balances that are not covered by insurance. Your credit card will be billed automatically for any unpaid balances. We do ask that you call us when you receive a statement if you would like to set up a payment plan. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, contact us immediately. We will try our best to set up a reasonable payment plan, if necessary. Payment on your account will be expected by the last day of each month. In the event that your account is not kept current, we reserve the right to send your account to collections. It is of utmost importance that you provide our office with complete responsible party information. It is our policy that we will collect payment at the time of service from any parent/guardian who may be bringing minor children to an appointment unless we are notified of other arrangements. In the event that there are legal or custody issues, please provide copies of legal documents to be kept as part of the patient's medical/financial record. Any patients with outstanding balances may be refused services in our offices until arrangements can be made with our billing department. We reserve the right to charge credit cards for any balances. We reserve the right to apply interest charges to accounts in which any portion is unpaid 45 days from the date of service and to charge for returned checks. Should the account be sent to collections, you will be responsible for additional collection fees ($75) as well as court costs and reasonable legal fees, if necessary.

Patients seeking services that require a referral are solely responsible for obtaining proper referrals from their Primary Care Provider. If you do not have a referral for your visit, you will have the option of paying for the visit IN FULL at the time of service or you will need to reschedule your appointment until the referral has been secured. Our office makes every effort to remind you when referrals are needed, but at no time does securing the referral become the responsibility of our office.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Insurance Company	Insured ID #
-	-

Consent to Treatment

I consent to and authorize Core Health Chiropractic to administrate pelvic floor therapy treatment. I understand and am informed that, as in the practice of medicine, pelvic floor therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of pelvic floor therapy about any health problems or allergies I have, as well as medication I am taking. I understand that with the practice of pelvic floor therapy there are no guarantees that have been made to me regarding treatment and/or treatment results from pelvic floor therapy.

Notice of Privacy Practices

I hereby acknowledge that I have been made aware of Core Health Chiropractic's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain information

I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney or other health care organizations pertinent to my case. Further, I authorize Core Health to obtain needed information from my physician, insurance company, adjustor, attorney, and other health care organization pertinent to my case. These correspondence can be made via mailings, telephone, and/or facsimile.

Insurance Eligibility

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

Payment is due at the time of treatment. I agree to pay Core Health Chiropractic all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

Assignment & Release of Benefits

I hereby appoint Core Health Chiropractic as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer or Medicare, while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my plan. I also authorize Core Health Chiropractic to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent to my Plan to Core Health Chiropractic, and in the care that payment is made by my Plan to me, I agree to remit such payment in full to Core Health Chiropractic not later than ten (10) days after my receipt.

Appointments/Cancellations

We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. We expect you to keep all of your appointments with Core Health Chiropractic and require 24 hours notice if you are unable to keep an appointment. Failure to show up for an appointment or provide proper notice will result in a $50.00 charge. These charges are not reimbursed by any insurance company.

Consent for Pelvic Floor Treatment

I understand that my treatment may include an initial internal pelvic exam, if warranted by my therapist, and potentially the need for subsequent treatment sessions involving internal manual techniques. This is only with my continuous consent during each session, after further discussion with my therapist, and upon receiving a copy of an additional consent form during my first session.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Signature	Date Signed -
Printed Name -	Email -