THE IDAHO CENTER FOR INTEGRATIVE MEDICINE

3271 N. Milwaukee St.
Boise, ID 83704
tel: (208) 629-5374 | fax: (208) 629-5394
www.theICIM.com

NEW PATIENT INFORMATION FORM

Personal:
Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Cell: (____) _____ Email: _____

Birth date: _____ Sex: M / F Marital Status: M / S Social Security #: _____

Ethnicity/Race: _____ Date of Injury:_____

Emergency Contact: _____ Phone: (_____) _____

Work:
Occupation: _____ Employer: _____ Office #: _____

Primary Insurance Information:
Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Member ID Number: _____ Group Number: _____

Secondary Insurance Information:
Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Member ID Number: _____ Group Number: _____

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. **It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not covered by your insurance or other third party payers. Your signature indicates that you agree to pay for any outstanding bills incurred in this office.** It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible. I authorize that payment be made directly to either Dr. Noah Edvalson or Boise Integrated Chiropractic at 3271 N. Milwaukee, Boise, ID 83704 for any and all insurance benefits or reimbursement for services rendered by him. I also authorize the release of any information concerning my health and healthcare services to my insurance companies, Medicare, or other pre-paid healthcare plans**. I understand that there is no guarantee that my insurance companies or pre-paid healthcare plan will cover or pay for all of my charges, and I understand that I am responsible for all remaining charges.**

_____ _____
Patient Signature Date

HEALTH INFORMATION FORM

Patient name: _____ Date: _____

Whom may we thank for referring you to our office? _____

Do you have a medical doctor? ____Yes ____No If yes, Doctor's name: _____

Doctor's phone number: _____ Approx date of last visit: _____

Family History:

Please indicate if anyone in your immediate family has a history of the following:

Arthritis ____No ____Yes Relationship_____ Disease _____

Heart Disease/Stroke ____No ____Yes Relationship_____ Disease_____

Cancer ____No ____Yes Relationship_____ Disease_____

Diabetes ____No ____Yes Relationship_____ Disease_____

Genetic Disorders ____No ____Yes Relationship_____ Disease_____

Past History

Please indicate if you have had any of the following:

Surgeries ____Yes ____No Describe _____

Hospitalizations ____Yes ____No Describe _____

Major Injuries ____Yes ____No Describe _____

Major Illnesses ____Yes ____No Describe _____

General Health Questions:

Blood Pressure_____ Weight:_____(in pounds) Height:_____(in inches)

List all Medications: _____ _____

List all Allergies (food, medication):_____

Do you currently smoke tobacco of any kind? ____Yes _____Never a smoker ____ Former smoker

If yes, how often do you smoke: ___ Current Everyday smoker ____ Current Someday smoker

If yes, what is your level of interest in quitting smoking: 0 1 2 3 4 5 6 7 8 9 10

Has any doctor diagnosed you with Hypertension presently? ____ Yes _____No

Has any doctor diagnosed you with Diabetes presently? _____Yes _____No

If yes, was your blood work test for hemoglobin A1c > 9.0% ____Yes ____No

Reason for Visit:

What is your primary complaint? _____

How severe is your pain? 0=no pain, 10=unbearable pain 0 1 2 3 4 5 6 7 8 9 10

What treatment have you had for these complaints?_____

Have you had x-rays, MRI's or other tests for this condition? ____Y ____N Date:_____

Location_____ Type:_____

Patient Name: _____ **Date:** _____

Review of Systems

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

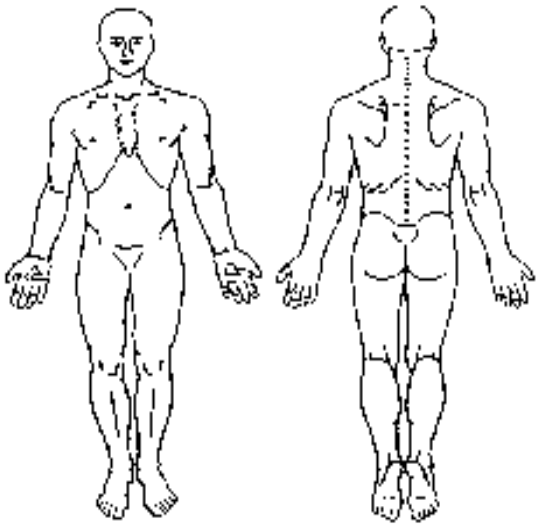
(Note whether in **PAST** or **NOW**)

PAST	NOW	
		MUSCUO-SKELETAL
☐	☐	Arm Pain
☐	☐	Fractures
☐	☐	Gout
☐	☐	Headaches
☐	☐	Herniated Disk
☐	☐	Jaw (TMJ) clicking/pain
☐	☐	Joint Pain/Stiffness
☐	☐	Low Back Pain
☐	☐	Neck Pain
☐	☐	Osteoporosis
☐	☐	Upper Back Pain
☐	☐	Walking Problems
		NERVOUS SYSTEM
☐	☐	Cold/Tingling Extremities
☐	☐	Confusion/Dementia
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Epilepsy
☐	☐	Fainting
☐	☐	Forgetfulness
☐	☐	Numbness
☐	☐	Paralysis
		MALE/FEMALE
☐	☐	Breast Pain/Lumps
☐	☐	Currently Pregnant
☐	☐	Genital Herpes
☐	☐	Menstrual Cramping
☐	☐	Menstrual Irregularity
☐	☐	Prostate/Sex Dysfct
☐	☐	Vaginal Pain/Infection
		MENTAL HEALTH
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Mental Disorder
☐	☐	Psychiatric Care
☐	☐	Suicide Attempt
		EENT
☐	☐	Cataracts
☐	☐	Dental Problems
☐	☐	Ear Aches
☐	☐	Glaucoma
☐	☐	Hearing Difficulty
☐	☐	Sore Throat
☐	☐	Stuffed/Runny Nose
☐	☐	Vision Problems

PAST	NOW	
		GENITO-URINARY
☐	☐	Discolored Urine
☐	☐	Incontinence
☐	☐	Kidney Disease
☐	☐	Painful/Excess Urination
☐	☐	Pelvic Pain
☐	☐	Venereal Infection
		HEART/LUNGS
☐	☐	Anemia
☐	☐	Ankle Swelling
☐	☐	Asthma
☐	☐	Blood Pressure probs
☐	☐	Chest Pain
☐	☐	Emphysema
☐	☐	Heart Disease
☐	☐	Irregular Heartbeat
☐	☐	Lung Probs/Congestion
☐	☐	Pneumonia
☐	☐	Shortness of Breath
☐	☐	Stroke
☐	☐	Varicose Veins
		INFECTIONS
☐	☐	Chicken Pox
☐	☐	Diphtheria
☐	☐	Influenza
☐	☐	Malaria
☐	☐	Measles/Mumps
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Small Pox
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Whooping Cough
		METABOLIC
☐	☐	Anorexia
☐	☐	Diabetes
☐	☐	Goiter

PAST	NOW	
		GASTRO-INTESTINAL
☐	☐	Abdominal pain
☐	☐	Appendicitis
☐	☐	Black/Bloody Stools
☐	☐	Colitis
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive Thirst
☐	☐	Gall Bladder Trouble
☐	☐	Gas/Bloating After Meals
☐	☐	Heartburn
☐	☐	Hemorrhoids
☐	☐	Hepatitis
☐	☐	Liver Disease
☐	☐	Liver Disease
☐	☐	Nausea
☐	☐	Poor/Excessive Appetite
☐	☐	Ulcers
☐	☐	Vomiting
☐	☐	Weight Gain/Loss
		GENERAL
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Cancer
☐	☐	Eczema
☐	☐	Fever
☐	☐	Insomnia
☐	☐	Migraines
☐	☐	Night Sweats
☐	☐	Sores not healing
☐	☐	Tumors

Please draw the area of your complaint



Consent to Treat and Authorization to Release Information

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient.

The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extra spinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, soft tissue manipulation, taping, exercise, nutritional supplementation, minor surgery, intravenous therapy, stitching, and any other procedures as prescribed by the doctor.

The doctors and staff make every effort within their power to minimize risks involved in any procedure. In spite of that, there may be a very small risk of complications.

I have read the above information and by my signature give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

I hereby provide authorization for the provider and staff to complete insurance claims as I may request, and understand that records will be held in confidence and not released for any other purpose.

____ **(initials)** I have been given the HIPAA form to review, and I agree to its contents.

_____ _____

Patient Date

_____

Signature

_____ _____

Signature of Parent (if Minor) Date

Energetic Fitness Systems Usage Waiver Agreement

I, the undersigned, acknowledge, represent and agree that:

_____(**initials**) I do not have an installed pacemaker or any other implanted electrical device, including, but not limited to, a hearing aid in or attached to my body.

_____(**initials**) I understand that the Energetic Fitness System equipment utilizes electrical forces to influence the energy fields within and surrounding my body.

As an inducement to Energetic Fitness Systems and The ICIM to allow me to use the Energetic Fitness System equipment, I hold harmless, Energetic Fitness Systems of PMB 250, 2950 Newmarket Street, Suite 101 Bellingham, WA 98226 and The ICIM, located in 3271 N. Milwaukee, Boise, ID 83704 from any and all consequences, either known or unknown, of whatever nature or kind.

I am aware that the Energetic Fitness Systems equipment is an experimental instrument and not intended nor represented to be a medical device for the diagnosis or treatment of any physical ailment or disease, nor is it a substitute for proper medical care administered by a licensed physician.

_____ _____

Signature **Date**

ICIM FINANCIAL POLICY

In Order to avoid any misunderstanding, the ICIM provides the following financial policies:

General:

All accounts are due and payable upon receipt of a mailed patient statement unless other arrangements are made at the time of service. Deductibles and co-pays are due at the time of service.

Accounts over 30 days of the first mailed statement will accrue a finance charge of 1.5% per month or 18% per year. Any and all accounts owing over 90 days may be turned over to a collection agency and may accrue a finance charge at the rate of 2% per month or 24% per year.

A $35.00 returned check charge will be added to all returned checks.

The Idaho Center for Integrative Medicine (ICIM) has one set fee schedule; however the amount that patients are responsible for will vary depending on their benefit coverage. If patients do not have private health insurance, Medicaid, Medicare, or other covered benefit plan, they are entitled to a "Time of Service" discount. Under this discount plan, payments are expected the same day the service was performed, and in exchange for prompt payments, the ICIM will offer 10-20% discounts depending on applicable laws (the government restricts the amount that can be discounted legally). The exact discount can be determined at the front office. Under certain circumstances, **Financial Hardship plans** are accepted by the ICIM, and if you feel as though your financial circumstances are such that you may require discounts beyond the customary Time of Service discounts, please inquire options at the front office. A Financial Hardship Form must be signed in these cases.

Health Insurance:

Your insurance is a contract between you and the insurance company. For your convenience, we will be happy to submit your charges to your insurance company. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Work Comp:

If you are involved in a work-related injury, your employer and/or worker's comp insurance policy is responsible for the cost of care. You will not receive a bill once the insurance carrier/employer has accepted the claim. You are responsible for creating the claim with your employer, and the claim number will be needed in order to receive treatment in our office.

Auto Injury:

If you are injured in a motor vehicle accident, we will submit claims to your own auto insurance even if you are not at fault. If you have Med Pay on your auto insurance, your treatment is covered until the Med pay runs out or treatment is finished. Your Med Pay carrier is responsible to pay over the course of care, while the insurance of the liable party will only pay at the time of settlement. When your Med Pay is exhausted we may submit claims to your group health carrier or make other arrangements with you. You may be asked to sign an Assignment Agreement so we can submit bills to your auto insurance and/or attorney and receive payments directly from them. Even if you are not at fault in an accident, there is no guarantee that treatment rendered in this office will be covered, and you are personally responsible for all charges incurred in the office.

Medicare, Medicaid:

We accept patients with Medicare and/ or Medicaid coverage. These programs provide limited coverage and do not pay for commonly used procedures in this clinic including myofascial release, exercises, PT modalities, and examinations. Medicare patients are responsible for deductibles, co-pays and all of these non-covered services. Medicare patients are required to fill out an Advanced Beneficiary Notice (ABN) form that will show the costs of the common non-covered services. Medicaid patients are responsible for non-covered services, but are not responsible for deductibles or co-pays.

My signature indicates I have read and understand this financial policy.

Signature: _____ Date: _____