Renova Medical Center, LLC

1401 Forum Blvd., Suite 202, Columbia, MO 65203

Patient Name_____ Date: _____

Email: _____SS #/SIN_____ DOB_____ □Male □Female

Home phone_____ Cell Phone _____

Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Patient's Address _____City _____ State_____ Zip_____

Spouse or Patient's Guardian name_____ Home Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

Responsible Party

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

Address _____ Home Phone _____

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

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence. Yes or No

_____

Parent or Guardian

Do you have any Medical Insurance? □ Yes □ No (If insurance card copy attached, only answer highlighted)

Name of the insured _____**Relationship to patient**_____

Insured Birthdate_____ SS#/SIN_____

Name of Employer_____ Address _____State _____Zip_____

Insurance Company_____ Insurance ID#_____ Group #_____

Ins. Co. Address _____City _____ State _____ Zip_____

Secondary Insurance Company_____ Insurance ID #_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS ANAPPOINTMENT 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 **Renova Medical Center, LLC** 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 or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)

Health History

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?)

Do you feel like your condition is getting better? Worse? Or staying the same?

_____

(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.)

Tingling in feet	NO	YES	Anemia	NO	YES
Back Surgery	NO	YES	Tingling in Hands	NO	YES
Knee Pain	NO	YES	Neck Surgery	NO	YES
Hight Blood Pressure	NO	YES	Back Pain	NO	YES
Cold Hands and Feet	NO	YES	Epilepsy	NO	YES
Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Erectile Dysfunction	NO	YES	Migraine Headaches	NO	YES
Ankle Surgery	NO	YES	Thyroid Disease	NO	YES
Carpal Tunnel Syndrome	NO	YES	Tuberculosis	NO	YES
Bleeding Tendency	NO	YES	Drop Foot	NO	YES
Retinopathy	NO	YES	Asthma	NO	YES
Cancer	NO	YES	Heart Attack	NO	YES
Pneumonia	NO	YES	COPD	NO	YES
AIDS & HIV	NO	YES	Diabetes	NO	YES
Glaucoma	NO	YES	Rheumatoid Arthritis	NO	YES
Arthritis	NO	YES	Infectious Mono	NO	YES
Balance Issues	NO	YES	Hernia	NO	YES
Organ Transplant	NO	YES	Received Chemotherapy	NO	YES
Any Other Disease	NO	YES	Stroke	NO	YES

Do you have a pacemaker or defibrillator NO YES

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication:(include nonprescription) – Write only "list on file" if you provided a list of the medications copied/attached.

_____

_____

_____

_____

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:_____

RENOVA MEDICAL CENTER, LLC
CONSENT TO TREAT

I hereby request and consent to the performance of medical treatment and manual therapy techniques and other therapeutic procedures, including various modes of physical therapeutic modalities and procedures, injections when warranted, and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the Medical Doctor or Nurse Practitioner named below and/or other licensed doctors of Medicine, Chiropractic, APRN's, licensed practicing nurse, registered nurse, who now or in the future work at the clinic or office listed below.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Dr. Robert Calaluce – Supervising Medical Physician

Joni Ahearn APRN – Nurse Practitioner

Shane Holloway FNP-C – Nurse Practitioner

Dr. Wael Mourad – Supervising Medical Physician

Rachael Goodman APRN – Nurse Practitioner

Dr. Aaron Rose – Doctor of Chiropractic