SYMPTOMS AND MEDICAL HISTORY

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Reason For Visit: (use diagram to indicate location of problem if applicable) _____

How Long Have Symptoms Been Present? _____

What Makes The Symptoms Worse? _____

What Makes The Symptoms Better? _____

What Treatments Have You Tried? (medications, therapy, injections, surgeries, etc.)

_____

Other Medical Problems: _____

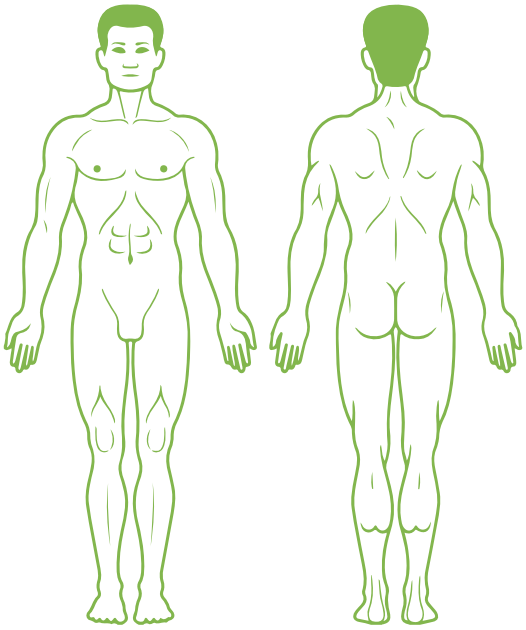
Previous Surgeries: _____

Medications/Supplements (name and dose): _____

_____

Allergies: _____

Family History of Medical Problems: _____



INDICATE WITH A CHECKMARK IF YOU HAVE A HISTORY OF:

- ☐ Smoking - If so, how much? _____
- ☐ Alcohol use - If so, how much? _____
- ☐ Non-prescription drug use - Which drug? _____
- ☐ Current use of blood thinning medication – Which medication? _____

- ☐ Recent infection
- ☐ HIV/AIDS
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Vasculitis
- ☐ Blood clots
- ☐ Transfusion reaction

REVIEW OF SYMPTOMS - PLEASE CHECK ANY AND ALL THAT APPLY:

- ☐ Fatigue
- ☐ Pregnant or may become pregnant
- ☐ Fevers
- ☐ Rashes
- ☐ Bruising
- ☐ Headaches
- ☐ Blurred vision
- ☐ Sore throat
- ☐ Weight loss
- ☐ Low libido
- ☐ Weight gain
- ☐ Anxiety
- ☐ Depression
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Fogginess
- ☐ Memory loss
- ☐ Difficult with speech
- ☐ Chest pain
- ☐ Palpitations
- ☐ Rapid heart beat
- ☐ Murmur
- ☐ Blood clots
- ☐ Cough
- ☐ Loss of hair
- ☐ Shortness of breath
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Blood in stool
- ☐ Blood in the urine

PATIENT INFORMATION

Name (Last, First)

Gender

Male ☐ Female ☐

Preferred Name

Date of Birth (DD/MM/YYYY)

Age

E-mail

Home Phone

Cell Phone

Street Address

City

State

Zip Code

Occupation

Employer

Who referred you to us or how did you hear about us?

PRIMARY CARE PHYSICIAN

Name

Office Phone

Fax

PREFERRED PHARMACY

Name

Phone Number

Street Address

City

State

Zip Code

EMERGENCY CONTACT

Name

Relationship

Phone Number

_____

Patient Signature

_____

Date

INERTIA MEDICAL, LLC
NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please contact us at (513) 570-4464. If you are not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

INERTIA MEDICAL, LLC NOTICE REGARDING YOUR RIGHT TO PRIVACY *continued...*

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____
Patient's Name	DOB
_____	_____
Patient's Signature	Date
_____	_____
Witness	Date

FINANCIAL AND OFFICE POLICIES

Thank you for choosing Inertia Medical as your healthcare provider. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies, or your financial responsibility, please let us know.

Services Rendered at Inertia Medical:

The patient is responsible for 100% of the payment.
Any patient has the option to submit a receipt of services to their insurance company.

Visit Fees:

Initial consultation	*$275*
Follow-up visits	*$175*

Procedure Fee Examples:

(Fees will be discussed prior to incurrence)	
Ultrasound or EMG	*No Additional Cost*
Muscle, Tendon, Joint, Nerve Injection (Anti-Inflammatory Medication)	*$20*
Platelet Rich Plasma (PRP)	*Starting at $499*
Bone Marrow Aspirate Concentrate (BMAC)	*$4,500*
Prolotherapy	*variable*
Shockwave Therapy	*$15*
Hyaluronic/Gel Injections	*$200 - $600*
Dry/Wet Needling	*Included In Visit Fee*
TENEX Tendon Therapy	*$2,499*

Returned checks:

Returned checks are subject to a $35 fee.

I have read, understand, and agree to the above financial and office policies:

_____ _____

Patient Signature Date