Utah Sports and Wellness - Dr. Michael J. Cerami

1550 East 3300 South | Salt Lake City, UT 84106 | 801-486-1818

Medical History

FOR YOUR FIRST APPOINTMENT: *Please wear loose fitting clothes. If you have a shoulder injury, wear a tank top or sports bra. If a leg injury, please wear shorts. Bring all paperwork and arrive 10 minutes early.*

Last Name: First Name:	Middle:	☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed	
Email:	Birth date:	Age:	Sex:
Address:	City:	State & ZIP:	
Best Phone #:	Social Security Number:	Referred By:	
Occupation:	Employer:	Work phone:	
Date of last doctors visit:	Date of last exam:		
Have you ever received chiropractic care?: ☐No ☐Yes, Name of Chiropractor:			
Your weight	Your shoe size	Height:	
WOMEN ONLY Is there ANY chance you might be pregnant?: ☐No ☐Yes	Are you on birth control?: ☐No ☐Yes		

What is (are) your specific concern(s)? :_____

_____

Did you sustain an injury? ☐No ☐Yes If so, when? _____

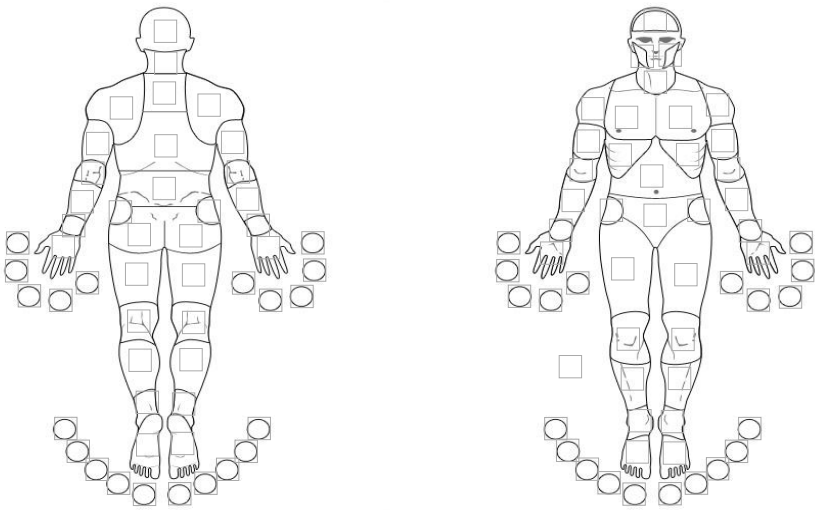
During what activity?_____

Date symptoms began: _____ Is condition Better: - AM/PM Worse - AM/PM

Activities that make condition better:_____

Activities that make condition worse: _____

Please use these diagrams to mark the location of the pain you have.



How long do you expect the repair process to take?

Are you on a special diet? ☐Yes ☐No If requested, will you keep a 2 week food diary?: ☐No ☐Yes

PATIENT CONDITION INFORMATION (limitations):

☐ Bending	☐ Lifting	☐ Running	☐ Sitting
☐ Standing	☐ Stairs	☐ Walking	☐ Biking
☐ Swimming	☐ Driving	☐ Twisting	☐ Other _____

INTERFERES WITH:

☐ Work ☐ Routine ☐ Sleep ☐ Exercise ☐ Lifting

PRESENT/PAST MEDIAL HISTORY (please check all that apply):

☐ Heart disease	☐ Prostate disease	☐ Liver disease	☐ Cervical spine disorder
☐ High blood pressure	☐ Bowel disease	☐ Severe headaches	☐ Lumbar spine disorder
☐ High cholesterol	☐ Cancer (past or present)	☐ Tuberculosis/TB	☐ Muscle disease
☐ Asthma	☐ Anemia	☐ Mental health problem	☐ Hypoglycemia
☐ Thyroid disease	☐ Blood clots/DVT	☐ Depression	☐ Chronic skin disease
☐ Stomach disease	☐ Bleeding tendency	☐ Stroke	☐ Nerve impairment
☐ Kidney disease	☐ Bladder disease	☐ Seizures	☐ Other _____

PERTINENT FAMILY MEDICAL HISTORY (cancer, heart disease, hypertension, etc):

_____

HOPITALIZATION and SURGERIES (last 10 years):

Approximate Date Purpose

_____ _____

_____ _____

_____ _____

CURRENT MEDICATION (includes non-prescription products)

Drug	Dose	Frequency	Drug	Dose	Frequency
1.			2.		
3.			4.		

SPECIAL CONSIDERATIONS:

☐ Spinal fusion (neck, low back)
☐ Pacemaker
☐ Attempted pregnancy
☐ Substance abuse or addiction
☐ Prefer "low-force" chiropractic adjustments
☐ Smoker ____ packs per day: _____
Other:_____
Describe: _____

ACTIVITY LEVEL:

☐ Competitive athlete ☐ Well-trained/frequent sports ☐ Occasional sports

What would you like your physician/team to accomplish today? (Please check all that apply)

☐ Chiropractic treatment ☐ Sports injury treatment ☐ Accurate diagnosis

☐ Nutrition plan ☐ Healthy exercise plan ☐ Other _____

Print Name: _____

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Terms of Acceptance

When a practice member seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working for the same goals.

New patients, or as we call them, practice members; usually want to get rid of whatever ailments or conditions are bothering them. In our opinion, most symptoms are an extension or an effect of other underlying problems that may have been present "below the surface" for some time. Our work is designed to find these dysfunctional patterns and interferences and correct them as quickly as possible. One common type of distortion pattern is spinal stress: this interferes with the function of nerve pathway and can stretch, pull and twist the spinal cord and associated muscles and boney structures. Unless these and other patterns are corrected, the patient may never achieve long-standing balance and symmetry and therefore never get to the level of improvement they expect. This is an example of why we take care of the entire body and not just focus on the symptomatic presentation.

We feel that improving the functional health of the patient will maximize the natural healing capacity of the body and therefore help to reduce the patient's symptoms.

Dr. Cerami uses a variety of techniques including, but not limited to, the traditional spinal adjustment or entrainment as well as muscle work and energy medicine tools such as cold laser therapy, frequency specific microcurrent and hyperbaric oxygen therapy. He will provide you with homework and recommendations to speed up your recovery. His clinical focus is to remove interferences in the body and restore normal function.

With a proper energy flow, health usually improves. Sometimes the changes are slow or present. Dr. Cerami cannot guarantee results in your case or in anyone's care. He will provide you options for treatment, let you decide how you would like to proceed and then give you his best advice and clinical care based on his experience and within his scope of practice.

Utah Sports and Wellness Mutual Agreement

1) *Utah Sports and Wellness consists of, and is limited to, surveying the spine, body, and joints to identify any area of nerve energy distortion and imbalance. Dr. Cerami uses his hands and other tools to correct these problems.*

2) *Utah Sports and Wellness does not include any treatment, cure or prevention of any mental, physical or emotional disorder of any kind, or the rendering of any opinion about the same.*

Patient Consent and Authorization

ALL patients initial at 1, 2, 3 – IF necessary initial at 4 or 5

1. ___ *Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such position.*

2. ___ *Release of Information: By my signature on this form, I am granting consent to Dr. Cerami to use and disclose protected health information for the purpose of treatments, payment and health care operations. Our Privacy Notice provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.* ***I authorize release of any information necessary to process insurance claims.***

3. ___ *Resolution of Disputes: In the rare circumstances that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with results of arbitration, I am free to pursue any other legal remedy at that time.*

4. ___ *(Female Patients Only) Verification on Non-Pregnancy: By signing on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.*

5. ___ *Permission to Evaluate and treat a Minor Child/Dependent Adult: I authorize Dr. Cerami to evaluate and treat:*

   Patient signature: _____ Date: _____

   Parent/Guardian :_____(Name of minor) _____ Date: _____

Office Financial Policy

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity and expertise required of the care rendered to you. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Our policy requires payment at time of service unless specified arrangements have been made in advance. You are financially responsible for services you receive; payment to our office is not contingent upon payment by your insurance company. If you wish to file your own insurance claims we will provide you with the necessary itemized statements to file for reimbursement.

New Patient Examinations: *Are required by law for any patients new to our office in addition to any previous patients out of care for* ***more than three (3) years****. This procedure is necessitated for patient safety and legal reasons which hold the doctor accountable for recording and responding to any changes in the patient's health.*

Reactivation Examinations: Any patient who has been out of care for ***more than 6 months*** will require a brief exam before receiving additional care. This procedure is necessitated for patient safety and legal reasons which hold the doctor accountable for recording and responding to any changes in the patient's health.

Missed Appointments: We charge $40 for any no shows or missed appointments not canceled within 24 hours of a scheduled visit; additionally, less than 24 hours' notice will incur a 50 percent charge of $20. We reserve the right to determine when an appointment has been missed.

Scheduled Appointments: Please be on time for each appointment you book. If you are late you may be required to wait up to 30 minutes for the next opening.

____ (Initials) **Office Visit Fees:** Office visits vary depending on the amount of clinical work that needs to be performed. ***Most regular visits run between $60 and $80.*** Extended office visits (new patient exams, reactivation exams, and private consultations) have separate fee schedules. All charges are due at time of service. We do not carry any patient balances.

___ (Initials) **Wellness Visit Package and Cancellation:** We offer a discount for patients interested in a series of wellness visits. Please inquire with the office manager for requirements and details on this plan. ***Pre-Payment plans expire 1 year from purchase date.*** Should you wish to terminate this plan early, the balance refunded shall be calculated at the per visit rate along with a $20 accounting charge-back fee. All refunds will be made within 21 days.

___ (Initials) **Past Due Accounts:** A finance charge of 1.5% per month will be charged on the unpaid balances of past due accounts. In the event that this account is submitted to a collection agency, customer will pay all attorney fees, court costs, filing fees, and all collection costs.

____ (Initials) **Insurance:** Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic or nutritional services. Your individual policy may cover all or none of our care as we are not affiliated with any insurance carriers and considered "out of network". If chiropractic or nutritional services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or by your employer. If it is determined that your insurance will cover your care in our office, we will work with you by filing the insurance claims for you to receive your entitled benefits. **Please understand that you are responsible to pay for all services not covered by your insurance company including deductibles, co-payments and any other balances not covered or reimbursed by the insurance company.** From time to time insurance carriers request information from us to qualify your care. It is our policy to provide a report that is consistent with the care that we provide upon receipt of a $60. payment by your company. These reports are extremely time consuming, and should your company refuse to pay the $60., the payment will be your responsibility before any report can be submitted. Utah Sports and Wellness specifically represents to the patient that we cannot guarantee that the services rendered can prevent or cure any illness, injury or disease.

I have read the above, understand it completely, and agree to undertake care at Utah Sports and Wellness by its terms.

Name (Please Print): _____

Signature: _____ Date: _____

Parent/Guardian's Signature (If patient is under 18 years old): _____