NEW PATIENT INFORMATION

GENERAL INFORMATION

1. **Last Name**: ______________________ **First Name**: ______________________ **MI**:____ **M / F**

   Address: ______________________ **City, State**: ____________ **Zip Code**: ________

   SSN: ______________________ **DOB**: ____/____/____

   Please indicate phone number(s) where SpineOne staff may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information.

   Home Phone: ______________ **Msg OK?** Y N **Emergency Contact**: ______________

   Work Phone: ______________ **Msg OK?** Y N **Relationship**: ______________

   Cell Phone: ______________ **Msg OK?** Y N **Phone**: ______________

2. **Referred by** (circle one): Yellow Pages – Internet – Signs – Friend – Family – Insurance – Employer – Physician – Attorney

   (Please provide name, address and phone): ______________________

3. Is this visit due to (circle one): AUTO ACCIDENT – WORK-RELATED INJURY – OTHER INJURY – NO INJURY

   Date of Injury/onset of symptoms: ____/____/____ (If unsure of exact date, give best guess of month and year).

INSURANCE INFORMATION

4. **Primary Insurance Company**: ______________________ Phone#: ______________

   Claims Address: ______________________

   ID/Claim# ______________ Grp/Policy#: ______________ Insured's Name: ______________

   Insured's SSN: ______________________ Insured's DOB: ___/___/___

5. **Other Insurance Company:** ______________________ Phone#: ______________

   Claims Address: ______________________

   ID/Claim# ______________ Grp/Policy#: ______________ Insured's Name: ______________

   Insured's SSN: ______________________ Insured's DOB: ___/___/___

6. **Have you retained an attorney?** YES NO (circle one) If yes, please provide name, complete address, and phone # below.

   Atty Name: ______________________ Phone: ______________

   Address: ______________________

I hereby request evaluation and treatment and grant this facility the authority to treat and examine me/my dependent and to order any examination or tests necessary to facilitate my examination or treatment. I understand that the practice of medicine is not an exact science and that there are no guarantees of the results and that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with any examination or treatment and that those risks will be presented and explained to me during the course of my treatment. I hereby authorize this facility and/or its clinical staff to perform examinations and treatment as necessary for my care.

Patient Signature: ______________________ ***Date***: ______________

RECORD RELEASE

CONSENT TO RELEASE PATIENT INFORMATION

________ (Initial) I hereby authorize the release of medical information including, but not limited to, medical history and physical examination, report of physical findings, x-rays and reports, MRIs and reports, diagnosis, prognosis, independent medical examinations, second opinion examinations, reports obtained from other physicians and providers involved with my medical care, both past and present, narrative reports, medical bills and treatment records and other such documents which may be requested from this office for the purpose of payment of claims, facilitating evaluation and/or treatment, facilitating a continuum of care and treatment, and/or arising out of any claim or action related to any aspect of my medical evaluation and treatment.

I expressly authorize the exchange of records and other documents listed above with any and all health care providers to whom I am referred to during the course of my treatment and/or any health care providers who have previously provided and/or presently provide any health-related services to me whose services may or may not be related to this accident, claim, injury or symptoms including but not limited to my primary care physician, pharmacist, etc.

Signature: **X** ______________________________ **DATE** ______________

Signature of Witness: X ______________________________ DATE ______________

Updated 03-26-07

PATIENT QUESTIONNAIRE

Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe your symptoms:

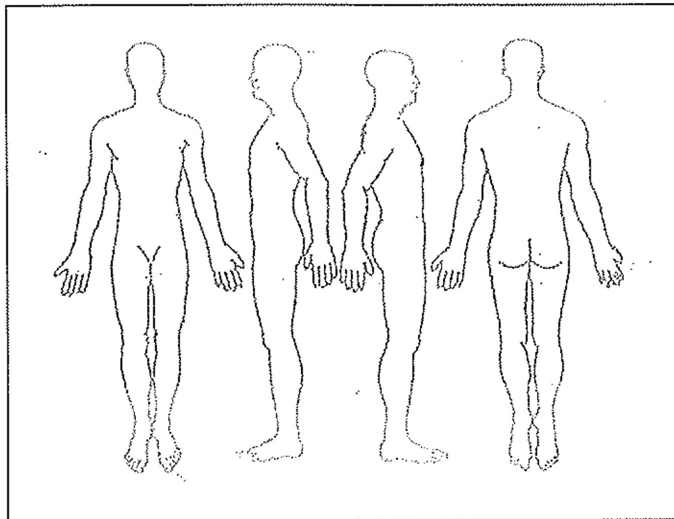
Pain ^ ^ ^

Numbness = = =

Pins & Needles 0 0 0

Burning X X X

Stabbing ////



Using the scale, what is your pain TODAY (please circle):

0 1 2 3 4 5 6 7 8 9 10
No pain - - - - - - - - - - - - - - - Worst Pain Imaginable

Please list your symptoms in order of their severity, most significant or painful symptoms first.

	Symptom(s)	Date symptoms appeared
1.	______	___/___/___
2.	______	___/___/___
3.	______	___/___/___
4.	______	___/___/___
5.	______	___/___/___

Yes No Can you relate your symptoms to any specific event/activity? Date of event/activity ___/___/___
If yes, please describe: ______

______

Yes No Are your symptoms related to an auto accident or work-related injury?
Date of auto accident ___/___/___ State _____ **-OR-** Date of work-related injury ___/___/___
How did the injury occur? ______

______

Yes No Have you received treatment for these symptoms in the past? If yes, please answer the following, beginning with your most recent treatment:

1. Name and location of provider: ______
Date(s) seen: ______ How many times? ______
Treatment received: ☐ Physical therapy/exercise ☐ Massage ☐ Chiropractic ☐ Injections ☐ Surgery
☐ X-rays, CT scans, MRI: Which body areas? ______
☐ Prescriptions or medications? (please list): ______

2. Name and location of provider: ______
Date(s) seen: ______ How many times? ______
Treatment received: ☐ Physical therapy/exercise ☐ Massage ☐ Chiropractic ☐ Injections ☐ Surgery
☐ X-rays, CT scans, MRI: Which body areas? ______
☐ Prescriptions or medications? (please list): ______

HEALTH HISTORY

I AM: ☐ Male ☐ Female Age:______ Height:______ Weight:______ ☐ Right-Handed ☐ Left-Handed

I AM: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you have any children? **Y** **N** List Ages: ________

Yes No Is there a chance you are pregnant? Due Date: ______________

Yes No I currently have a primary care physician/clinic – Name: ______________________________

Yes No Are you currently being treated for other health problems and/or have chronic health problems?
Please describe: ____

Yes No Have you experienced prior accidents, injuries, falls, physical trauma, and/or injuries to your neck/back?
Please describe: ____

Yes No Have you ever been hospitalized overnight for any reason and/or had any prior surgeries?

Please list:

Date or Age	Reason for Hospitalization/Type of Surgery	Hospital/Facility

Yes No Are you currently taking any medications? Please list: ______________________________

Yes No Do you have any allergies to medications? Please list: ______________________________

Yes No Do you smoke? How many cigarettes/packs per day? _________ For how long? ___________

Yes No Do you drink alcohol? How often? ______________________________

Yes No Do you use any drugs/substances not prescribed by a physician? Please describe: ______________

Is any of the following known to exist in your family medical history?

Yes No Rheumatoid Arthritis/Osteoarthritis

Yes No Other Auto-Immune Diseases

Yes No Other Diseases/Problems with the neck and/or back

My job title/occupation is: ____

My current employer is: ____

Yes No Have you missed any work as a result of your symptoms? How many days? ______________

Yes No Are there any other health problems you currently have and/or have been treated for that have not been identified or listed? Please describe: ______________________________

Yes No I have previously been treated by a physician/therapist at this office.

Patient Signature: ______________________________ ***Date***: ______________

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of, **[SpineOne]** ("**SpineOne**" or "Office") in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment, supplies, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my charges"). I further grant a contractual lien to **SpineOne** with respect to my charges. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, general auto coverage, uninsured and underinsured motorist coverage, liability coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay **SpineOne**, I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to **SpineOne**, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to **SpineOne** regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct **SpineOne** to file my claims with my health insurance, auto insurance, or third-party insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, med pay, attorneys, etc.), I hereby authorize and direct **SpineOne** to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release to **SpineOne** any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I hereby authorize **SpineOne** to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents for treatment received. I further authorize **SpineOne** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition. I understand that I remain personally responsible for the total amounts due to **SpineOne** for their services.

This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **SpineOne** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **SpineOne** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **SpineOne** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): ______________________________

Patient Signature: ______________________________ Date: ______________

Name of Custodial Parent or Legal Guardian (please print): ______________________________

Parent/Guardian's Signature: ______________________________ Date: ______________

FINANCIAL POLICY

It is the policy of SpineOne, P.C., as a courtesy to you, to file insurance claims with your individual insurance company. You will be responsible for **all deductibles, copays, and co-insurance as outlined in your individual contract.**

Office deductibles and co-insurance amounts must be paid at the time of service, and all patients must pay their co-pay before services are rendered. For those patients who are un-insured or under-insured our cash payment option offers re-priced amounts for services rendered. Payment must be made at the time of service in order to qualify. If payment is not made at the time of service, full usual and customary charges will be billed.

Our billing department will be happy to help you with questions regarding your insurance or payment options, but YOU are ultimately responsible for payment regardless of your insurance coverage. Please check with your insurance carrier prior to receiving services and be aware of any restrictions or clauses that could reduce your benefits such as, second opinions, pre-existing conditions, review for hospital admissions, referrals from your primary care physicians, etc. If you are a member of an HMO or PPO in which SpineOne, P.C. physicians are providers; this does not waive your responsibility to confirm coverage. Your benefits could be significantly reduced for all out-of-network services which become your responsibility and payment required in full, using the Cash or Care Credit options outlined above.

When an office visit or procedure has been pre-authorized or pre-certified, this does not guarantee full payment by your insurance company. Please contact your insurance company with any questions.

In addition to SpineOne, P.C. facilities and physician charges, you may receive charges from other entities including, but not limited to, anesthesia and outside diagnostic laboratory services.

By my signature, I confirm that I have read and understand the above information; I understand that SpineOne, P.C., its physicians and/or staff are not responsible for my insurance coverage, pre-authorization, or any other insurance decisions.

Please initial one of the following options:

_____ **This illness/injury is work-related.**

_____ **This illness/injury is NOT work-related.**

Patient Signature: ______________________________ ***Date***: ____________________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES wherein a more detailed description of the uses, examples of and disclosures of my personal health information ("PHI") exists. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this office at any time at the address noted on this form if I wish to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, facilitate payment or facilitate/comply with health care operations. I also understand that you are not required to agree or abide by my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Name of Authorized Patient Representative if NOT patient: ______________________________

Relationship of Authorized Patient Representative to patient: ______________________________

X______________________________ ______________________________
Signature of Patient/Authorized Patient Representative *Date*

I certify that I attempted to obtain the signature of the patient and/or authorized representative in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to obtain the patient's signature as indicated below:

- ☐ Patient cannot write due to learning disability/language barrier.
- ☐ Patient was seen on emergency basis and was physically incapacitated and unable to sign name at time of presentation to office.
- ☐ Patient cannot read English and language interpretation was not available.
- ☐ Patient's authorized representative (legal power of attorney, legal parent, legal guardian, etc.) was unavailable to sign.
- ☐ Patient refused to sign NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT stating his/her refusal is due to:

____

Patient/Authorized Representative was presented with this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT and refused to sign this document on:

X______________________________ ______________________________
Signature of Employee/Witness *Date*