# 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: _____
   Email: _____
   What is your preferred method of contact for an appointment reminder? e-mail ○ text ○ voice message

2. Is this visit due to a/an: Auto Accident ○ Work-related injury ○ Other injury ○ No injury
   Date of Injury/onset of symptoms: _____/_____/_____
   (If you are unsure of the exact date, give the best guess of month and year)

## INSURANCE INFORMATION

3. **Primary Insurance Company:** _____ Phone#: _____
   Claims_ Address: _____
   ID/Claim#: _____Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

4. **Other Insurance Company**: _____ Phone#:_____
   Claims_ Address: _____
   ID/Claim#: _____ Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

5. **Have you retained an attorney or will you be retaining an attorney?** YES ○ NO
   If yes, please provide name, complete address and phone number below.

   Atty Name: _____ Phone#: _____
   Atty 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 particu lar 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: _____/_____/_____

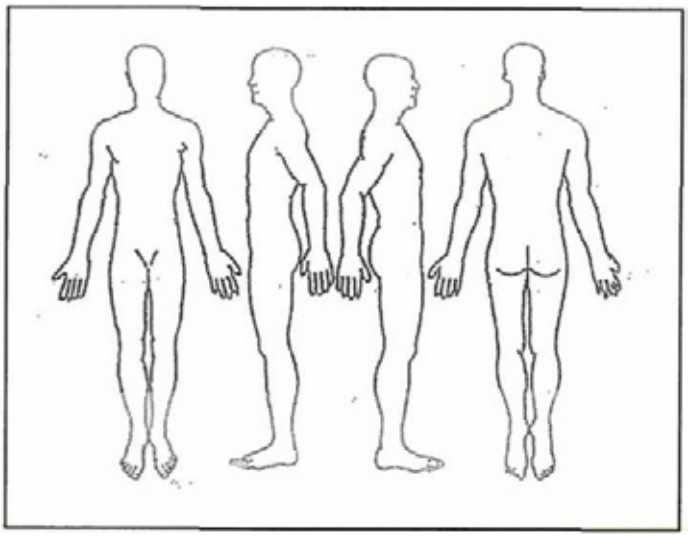
PRINT

If you do not have a digital signature, you may print, sign and bring this form into SpineOne with you.

# PATIENT QUESTIONNAIRE FOR AUTO-RELATED INJURY

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

- Pain +
- Numbness 0
- Pins & Needles #
- Burning X
- Stabbing /



Using the scale, what is your pain TODAY?

0 No Pain
1 ○
2 ○
3 ○
4 ○
5 ○
6 ○
7 ○
8 ○
9 ○
10 ○ Worst Pain

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

Symptom(s): Date symptom(s) appeared:

1. _____ _____ / _____/_____
2. _____ _____ / _____/_____
3. _____ _____ / _____/_____
4. _____ _____ / _____/_____
5. _____ _____ / _____/_____

**Auto accident date**: ____ / ____/_____ **State of occurence:** _____ **Reported to your insurance?** Yes No ○

Please describe how the accident occurred — include the estimated speed of your vehicle upon impact, the estimated speed of any other vehicle upon impact, and what area of your vehicle was impacted by another object or vehicle:

_____
_____
_____
_____

**At the time of impact, please indicate where you were sitting in the vehicle:**

Driver's seat Front seat passenger ○ Rear seat passenger—behind driver ○ Rear seat passenger—behind passenger

Were you wearing a seat-belt restraint? Yes No ○ Was your vehicle towed from the scene? Yes No ○

**Please describe the vehicles involved in the accident and the extent of physical damage to the vehicle (if known):**

| Vehicle | Year | Make/Model | Amount of property damage |
|---|---|---|---|
| YOUR VEHICLE | _____ | _____ | $_____ |
| VEHICLE #2 | _____ | _____ | $_____ |
| VEHICLE #3 | _____ | _____ | $_____ |

Yes No ○ Did any part of your body strike any part of the vehicle's interior? _____

Yes No ○ Were you knocked unconscious? For how long? _____

Please indicated if you sustained any of the following:

Yes No ○ Cuts/Lacerations—to what areas? _____

Yes No ○ Bruises/Abrasions—to what areas? _____

Yes No ○ Fractures dislocations—to what areas? _____

Yes No ◯ Did you have any immediate symptoms? Please describe:

_____
_____
_____

Yes No ◯ Were the police called to the scene?

Yes No ◯ Was an ambulance/paramedics called to the scene?

Yes No ◯ Did you receive medical treatment at the scene? If yes, please describe:

_____
_____
_____
_____

Yes No ◯ Did you go immediately to the hospital from the scene of the accident? By ambulance ◯ car

Yes No ◯ Were you admitted for an overnight stay at the hospital? If yes, how many days? _____

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 Chiropractor 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 Chiropractor Injections Surgery

X-rays CT scans MRI: Which body areas? _____
Prescriptions or medications? (please list):

_____
_____
_____

PRINT

SpineOne

# HEALTH HISTORY

**I am:** Male ○ Female ○ Age:_____ Height:____ ft. ____ inches Weight: _____ lbs. Right Handed Left Handed ○

**I am:** Single Married ○ Divorced ○ Widowed ○ Do you have children? Yes No ○ List ages: _____ Yrs. _____ Mos.

Yes No ○ Are you pregnant? If yes, please provide a due date: _____/_____/_____

Yes No ○ Do you currently have a primary care physician? Clinic/Name: _____

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

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

Yes No ○ Have you been hospitalized for any reason and/or had any prior surgeries?
Please list:

| Date or age | Reason for hospitalization | Type of surgery | Facility |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

Yes No ○ Are you allergic to any medications? Please list: _____

Are you allergic to: Iodine? Yes No ○ | Shellfish? Yes No ○ | Contrast? Yes No ○

Yes No ○ Do you Smoke? If yes, how many packs/cigarettes a day? _____ Packs Cigarettes For how long? _____

Yes No ○ Do you drink alcohol? How often? _____ a day a week ○ a month ○

Yes No ○ Do you use any drugs not subscribed by a provider? Please describe: _____

**Are any of the following known to exist in your family-medical history?**

Yes No ○ Rheumatoid arthritis/osteoarthritis

Yes No Other Auto-immune diseases? Please list: _____

Yes No ○ Other diseases/problems with your neck/back? Please describe: _____

_____

_____

**My job title/occupation is:** _____

**My current employer is:** _____

Yes No ○ Have you missed any work as a result of your symptoms? If so, 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 ○ Have you previously been treated by a provider at this office?

***Patient Signature:*** _____ ***Date:*** _____/_____/_____

For office use only

Drug: _____
Route: _____
Lot #/Exp: _____
Initials: _____

MA:

PRINT

# HEAD INJURY CHECKLIST

1. Did you hit your head? Yes No ○ If yes, on what? _____

2. If so, where? ___Top ___Left side ___Right side ___Back ___Face ___Other

   If other, please describe: _____

3. Did you lose conconsciousness? Yes ○ No ○ Unknown ○ If so, for how long? Hours ___ Minutes ___
   If not, were you dazed after the accident? Yes ○ No ○

4. Do you have a history of head injuries? Yes ○ No ○ If yes, please describe _____

5. Do you have any of the following symptoms (please check all that apply)?

   A. Headache: Yes ○ No ○ If yes, how frequent are your headaches? ___ times per day ___times per week

      1. If yes, what part of your head? ___Top ___Left side ___Right side ___Back ___Forehead Other___

         If other, please describe _____

      2. How long did your headache(s) last? ___Hours ___Minutes ___All day

      3. Describe the pain: ___Throbbing ___Aching ___Other If other, please describe _____

      4. Are your headaches associated with: ___Nausea ___Vomiting ___Other

         If other, please describe _____

   B. Memory loss: ___for things that recently happened? ___for things in the remote past?

   C. Are you dizzy or light headed? Yes No ○

   D. Does the room spin? Yes No ○

   E. Do you have trouble concentrating? Yes No ○

   F. Do you sleep more or less than usual? Yes No ○

   G. Have you become irritable? Yes No ○

   H. Do you have trouble retaining new information? Yes No ○

   I. Do you have difficulty with calculations (like doing your checkbook)? Yes No ○

   K. Do you have trouble with walkng/balance? Yes No ○

   L. Do you have ringing in your ears? Yes No ○

PRINT

SpineOne

# REVIEW OF SYSTEMS CHECKLIST

Are you currently experiencing any of these symptoms? Pleae check all that apply.

**Respiratory:**
- Spitting up blood
- Shortness of breath
- Asthma or wheezing
- Frequent coughing
- None in this category

**Women Only:**
- Irregular periods
- Painful periods
- Vaginal discharge
- None in this category

Date of last menstrual period: _____/_____/_____

**Eyes and Vision:**
- Wear glasses/contacts
- Blurred or double vision
- Glaucoma
- Eye disease or injury
- None in this category

**Gastrointestinal:**
- Stomach pain
- Blood in stool
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Constipation
- Painful bowel movements
- Loss of appetite
- None in this category

**Neurological:**
- Frequent or recurring headaches
- Light headed or dizzy
- Convulsions or siezures
- Numbness or tingling sensations
- Tremors
- Stroke
- Have you ever had a head injury?
- Have you ever been in a car accident?
- None in this category

**Endocrine:**
- Thyroid problems
- Diabetes
- Excessive thirst or urination
- Cold extremeties
- Heat or cold intolerance
- Change in hat or glove size
- Dry skin
- Glandular hormone problem
- None in this category

**Skin and Breasts:**
- Rash or itching
- Change in skin color
- Change in hair or nails
- Non-healing sores
- Change in appearance of a mole
- Breast pain
- Breast lump
- Breast discharge
- None in this category

**Genitourinary**
- Sexual difficulty
- Kidney stones
- Burning or painful urination
- Blood in urine
- Change in force or strain with urination
- Incontinence or dribbling
- Frequent urination
- None in this category

**Musculoskeletal**
- Joint stiffness or swelling
- Weakness of joints
- Muscle pain or cramps
- Muscle weakness
- Neck pain
- Upper or mid-back pain
- Low-back pain
- Joint pain
- Difficulty walking
- None in this category

**Mind/Stress:**
- Nervousness
- Depression
- Sleep problems
- Memory loss or confusion
- None in this category

**Heart & Cardiovascular**
- Chest pains
- Sudden heartbeat changes
- Swelling of feet, ankles, hands
- Heart trouble
- None in this category

**Hematologic/Lymphatic**
- Swollen glands
- Easily bruise or bleed
- Anemia
- Phlebitis
- Transfusion
- Slow to heal after cuts
- None in this category

**General (constitutional)**
- Recent weight change
- Fever
- Fatigue
- None in this category

**Ears, nose, throat**
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck
- Mouth sores
- Ringing in the ears
- Earaches or drainage
- Sinus problems
- Hearing loss
- None in this category

PRINT

## Medical & Family History

Please list any past surgeries or hospitalizations:

Please list any prescription medications your currently take:

Do you have any allergies (environmental, food, medications, latex, other)?

Is there a family history of cancer or other disease? If yes, please list:

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION ("Authorization")**
(INCLUDING VERBAL DISCUSSION OF HEALTH INFORMATION)

---

Patient: _____ Date of Birth: ___/ ___/_____

Address: _____

I hereby authorize the following Affiliated Covered Entity including its agents and employees (collectively the "Healthcare Provider"):

| | | | |
|---|---|---|---|
| SpineOne, Inc.<br>8500 Park Meadows Dr.#200<br>Lone Tree, CO 80124<br>P: 303-500-8611 | Denver Metro Imaging, LLC<br>8500 Park Meadows Dr. #050<br>Lone Tree, CO 80214<br>P: 303-925-0674 | The Surgery Center at Lone Tree, LLC<br>8500 Park Meadows Dr. #100<br>Lone Tree, CO 80124<br>P: 303-951-7510 | Park Meadows Anesthesia, LLC<br>8500 Park Meadows Dr. #100<br>Lone Tree, CO 80124<br>P: 303-986-4190 |

to use or disclose "protected health information" of **(insert patient name below)**:

_____(the "Patient"), covered under privacy regulations and any amendments thereto issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule") as specified in this Authorization. I understand that "protected health information" may include records by other health care providers and facilities who previously provided treatment to the Patient.

Information to be Used or Disclosed:
I specifically authorize the Healthcare Provider to use or disclose the following (collectively the "Patient's Health Information and Records") (select appropriate boxes below):

Entire Medical Record  Most Recent 3 Years of Medical Records  Medical Billing Records
Imaging Studies (e.g., x-rays, photographs, MRIs, CTs, etc.)  Laboratory & Diagnostic Reports
Substance Use Records Only (alcohol/drug abuse information  HIV/AIDS related information  OTHER

Please specify a date range for the above selected Patient's Health Information and Records if applicable:
From ____ / _____ /_____  To ____ / _____ /_____

Lastly, I specifically authorize the Healthcare Provider to discuss, clarify, and provide explanation of the Patient's Health Information and Records to the Recipient(s) described below.

Person(s) Authorized to Make the Use or Disclosure:
I hereby authorize the Healthcare Provider to make the uses and disclosures specified in this Authorization.

Recipient(s) of Use or Disclosure: The Patient's Health Information and Records may specifically be used by or disclosed to _____

If the recipient is an entity, then the Patient's Health Information and Records may also be used by or disclosed to that entity's agents and employees. Furthermore, for the purposes of treatment, payment, and

operations, the Patient's Health Information and Records may also be used by or disclosed to healthcare providers the Patient is referred to, payors, and to current and past healthcare providers including but not limited to the Patient's primary care physician, pharmacist, etc.

**Purpose(s) of the Use or Disclosure:**
The purpose of the use or disclosure (other than for treatment, payment, and operations) is to provide the Patient's Health Information and Records at the request of the individual signed below.

**Additional Statements:**
This authorization will expire twelve (12) months from the date signed below.

I understand that I may revoke this Authorization by submitting a written revocation to the Healthcare Provider. However, such revocation will not be effective with respect to any use or disclosure made by the Healthcare Provider in reliance on this Authorization before the Healthcare Provider received my revocation.

I understand that this Authorization is voluntary and that the Healthcare Provider cannot condition the Patient's treatment, eligibility, or benefits on whether or not I sign this Authorization.

I understand that the Patient's Health Information and Records (except for Substance Use Records) used or disclosed by the Healthcare Provider pursuant to this Authorization may be subject to redisclosure by the recipient(s), in which case the Patient's Health Information and Records might no longer be protected under the HIPAA Privacy Rule.

I hereby release the Healthcare Provider from any liability, damages, and expenses arising in connection with the use or disclosure of the Patient's Health Information and Records pursuant to this Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

_____ ____ / _____ /_____
Patient Name Date

_____
Patient Signature

*Or, if applicable:*

_____ ____ / _____ /_____
Personal Representative Date

_____
Basis of Personal Representative's authority to sign for Patient

[NOTE: YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.]

PRINT

# 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. Ifthis 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): _____ Date: _____ / _____ /_____

Patient Signature: _____

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

Parent/Guardian's Signature: _____ Date: _____ / _____ /_____

PRINT

# 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.

If you have retained an attorney and your case is being handled on a lien basis we still require that you provide our office with your health insurance information; however, the attorney lien will be considered the primary responsible party for your case until the time of your settlement or the termination of attorney/client relationship , whichever occurs first.

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: ____ / ____ /_____

PRINT

# ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for SpineOne, Inc. and I acknowledge it applies to the following organizations as a single Affiliated Covered Entity:

- SpineOne, Inc.
- The Surgery Center at Lone Tree, LLC
- Park Meadows Anesthesia, LLC
- Denver Metro Imaging, LLC dba Park Meadows Imaging

_____ ____ / _____ /_____

Signature of Patient/ Authorized Representative Date

_____

Printed Name

_____

Patient Name (If different from above)