



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

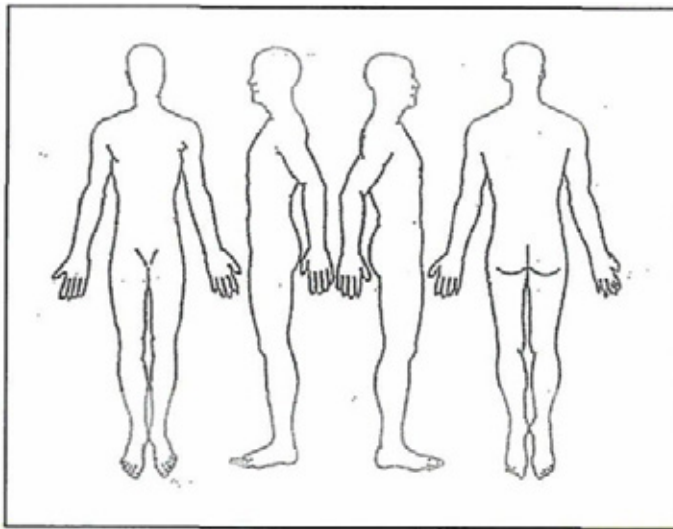
Patient Signature: _____ Date: ____/____/____

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

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 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. | | ___ / ___ / ___ |

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

Date of event/activity:
___ / ___ / ___

Yes No Are your symptoms related to an auto accident or work-related injury?

Date of accident: ___ / ___ / ___ Which state: _____ 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 questions, beginning with your most recent treatment.

1. Name and location of provider:

Dates seen:

How many times?

Treatment received:

Imaging done:

Which body parts?

Prescriptions:

2. Name and location of provider:

Dates seen:

How many times?

Treatment received:

Imaging done:

Which body parts?

Prescriptions:

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



REVIEW OF SYSTEMS CHECKLIST

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

<p>Respiratory:</p> <ul style="list-style-type: none"> Spitting up blood Shortness of breath Asthma or wheezing Frequent coughing None in this category 	<p>Women Only:</p> <ul style="list-style-type: none"> Irregular periods Painful periods Vaginal discharge None in this category <p>Date of last menstrual period: ____/____/____</p>	<p>Eyes and Vision:</p> <ul style="list-style-type: none"> Wear glasses/contacts Blurred or double vision Glaucoma Eye disease or injury None in this category
<p>Gastrointestinal:</p> <ul style="list-style-type: none"> 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 	<p>Neurological:</p> <ul style="list-style-type: none"> Frequent or recurring headaches Light headed or dizzy Convulsions or seizures 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 	<p>Endocrine:</p> <ul style="list-style-type: none"> Thyroid problems Diabetes Excessive thirst or urination Cold extremities Heat or cold intolerance Change in hat or glove size Dry skin Glandular hormone problem None in this category
<p>Skin and Breasts:</p> <ul style="list-style-type: none"> 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 	<p>Genitourinary</p> <ul style="list-style-type: none"> 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 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> 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
<p>Mind/Stress:</p> <ul style="list-style-type: none"> Nervousness Depression Sleep problems Memory loss or confusion None in this category <p>Heart & Cardiovascular</p> <ul style="list-style-type: none"> Chest pains Sudden heartbeat changes Swelling of feet, ankles, hands Heart trouble None in this category 	<p>Hematologic/Lymphatic</p> <ul style="list-style-type: none"> Swollen glands Easily bruise or bleed Anemia Phlebitis Transfusion Slow to heal after cuts None in this category <p>General (constitutional)</p> <ul style="list-style-type: none"> Recent weight change Fever Fatigue None in this category 	<p>Ears, nose, throat</p> <ul style="list-style-type: none"> 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

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:



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?
Please 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: _____



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): _____ Date: ____ / ____ / ____

Patient Signature: _____

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.

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: ____ / ____ / ____