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:** _____

   E-Mail: _____

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

   Date of Injury/onset of symptoms: _____/_____/_____ (If unsure, give best guess of month and year)

   Is there an open claim for your injury? (circle one) YES NO

3. Do you have a Primary Care Provider? (circle one) YES NO

   If yes, would you like your records to be forwarded to their office? (circle one) YES NO

   Name: _____ Office Name: _____

INSURANCE INFORMATION

4. Are you currently enrolled with Medicare or Medicaid? (circle one) YES NO

5. **Primary Insurance Company**: _____ Phone#: _____

   Claims Address: _____

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

   Insured's SSN: _____ Insured's DOB: ____/____/____

6. **Other Insurance Company:** _____ Phone#: _____

   Claims Address: _____

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

   Insured's SSN: _____ Insured's DOB: ____/____/____

7. **Have you retained an attorney or will you be retaining an attorney?** (circle one) YES NO

   If yes, please provide name, complete address, and phone # below.

   Attorney 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

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 FOR WORK-RELATED INJURY

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

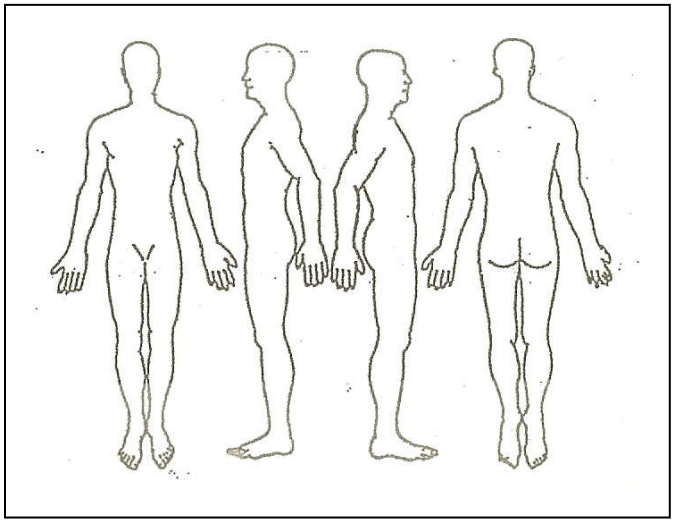
Pain ^ ^ ^

Numbness = = =

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

What was the date of your injury? ____/____/____

Please describe how the accident occurred – include the type of work activity you were doing, the equipment used at the time of your injury, approximate weight of any equipment involved, etc. _____

_____

_____

Yes No Did your injury occur at a site different from your employer's office/location? If yes, please identify the exact location where the injury occurred: _____

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

Please indicate if you sustained any of the following:

- ☐ Cuts/Lacerations – to what areas? _____
- ☐ Bruises/Abrasions – to what areas? _____
- ☐ Fractures/Dislocations – to what areas? _____

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

Yes No Did you receive any treatment at the scene of your injury? Please describe: _____

Yes No Was anyone else present at the time of your injury? If yes, please identify: _____

Yes No Have you ever experienced any prior trauma/injury/symptoms in the same area(s) of your body? Please describe:

_____

_____

Yes No Did you report the injury to your supervisor/employer? What date? ____/____/____

Yes No Did your supervisor/employer refer you to anyone for evaluation/treatment for your injury? If yes, please complete the next section on the following page:

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 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 Are you allergic to Iodine?

Yes No Are you allergic to Shellfish?

Yes No Are you allergic to Contrast?

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

Yes No Is there a family history of Cancer? If so, type? _____

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:*** _____

For Office Use Only:

Drug: _____
Route: _____
Lot Number/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): _____

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.

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***: _____

Review of Systems Checklist

Are you *currently* experiencing any of these symptoms (Check all that apply)?

Respiratory
___ Spitting up blood
___ Shortness of breath
___ Asthma or wheezing
___ Frequent coughing
___ 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

Skin and breasts
___ Rash or itching
___ Change in skin color
___ Change in hair or nails
___ Nonhealing sores
___ Change in appearance of a mole
___ Breast pain
___ Breast lump
___ Breast discharge
___ None in this category

Mind/Stress
___ Nervousness
___ Depression
___ Sleep problems
___ Memory loss or confusion
___ None in this category

Heart and Cardiovascular
___ Chest pains
___ Sudden heartbeat changes
___ Swelling of feet, ankles, hands
___ Heart trouble
___ None in this category

Women Only:
___ Irregular periods
___ Painful periods
___ Vaginal discharge
___ None in this category
___ Date of last menstrual period: _____

Neurological
___ Frequent or recurrent 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 auto accident?
___ 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

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

Eyes and vision
___ Wear glasses/contact lenses
___ Blurred or double vision
___ Glaucoma
___ Eye disease or injury
___ None in this category

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

Musculoskeletal
___ Joint stiffness or swelling
___ Weakness of muscles/joints
___ Muscle pain or cramps
___ Muscle weakness
___ Neck pain
___ Upper or mid back pain
___ Low back pain
___ Joint pain
___ Difficulty in walking
___ 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
___ Nose bleeds
___ Hearing loss
___ None in this category