

## CONFIDENTIAL PATIENT INFORMATION

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Children: # of \_\_\_\_\_

Education: # of years completed: \_\_\_\_\_  Full-time student  Part-time student  Non-student

Employed:  Full-time Work Status:  Working without restrictions  Not working/off work since \_\_\_\_\_  
 Part-time  Working with restrictions  Retired

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Job Description: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

**Date of injury, surgery, or onset of symptoms:** \_\_\_\_\_ **Emergency Contact, not living with you:**

**What type of injury are we seeing you for?** Name: \_\_\_\_\_  
 Auto  Sports Injury  No specific trauma Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Work  Slip & Fall  Other

### PATIENT'S AUTO/WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Claim #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Adjuster's Phone #: \_\_\_\_\_ Adjuster's Fax #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address of Insured: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

### PATIENT'S HEALTH INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Claim #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Adjuster's Phone #: \_\_\_\_\_ Adjuster's Fax #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address of Insured: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

I hereby consent to and authorize all treatment that may be advisable or necessary. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR SERVICES PROVIDED REGARDLESS OF MY INSURANCE STATUS. I will inform this office of any changes in medical history, insurance coverage, telephone and/or address changes as they occur. I certify this information is true and correct to the best of my knowledge. I hereby authorize and give specific Power of Attorney to Advanced Spine & Rehabilitation to endorse my name to any and all checks, drafts or money orders which are made payable to the undersigned and/or Advanced Spine & Rehabilitation, which are paid by my insurance company for services rendered to me.

Payment is expected at time of service for "Your Portion" of charges. We accept VISA/MASTERCARD for your convenience. There will be a charge of \$25 for all returned checks. If copies or records are requested, there is a charge of \$.60 per page.

In the event your account becomes past due, it may accrue interest at the rate of 1.5% per month (18% per annum). Your account may be referred to a Collection Agency for nonpayment. Interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all collection costs, attorney fees, court costs, service fees, and miscellaneous fees/costs (which could double the outstanding balance). Further, your signature authorizes Advanced Spine & Rehabilitation to release any medical information necessary to process your insurance claim. Your signature below indicates that you understand and accept these policies.

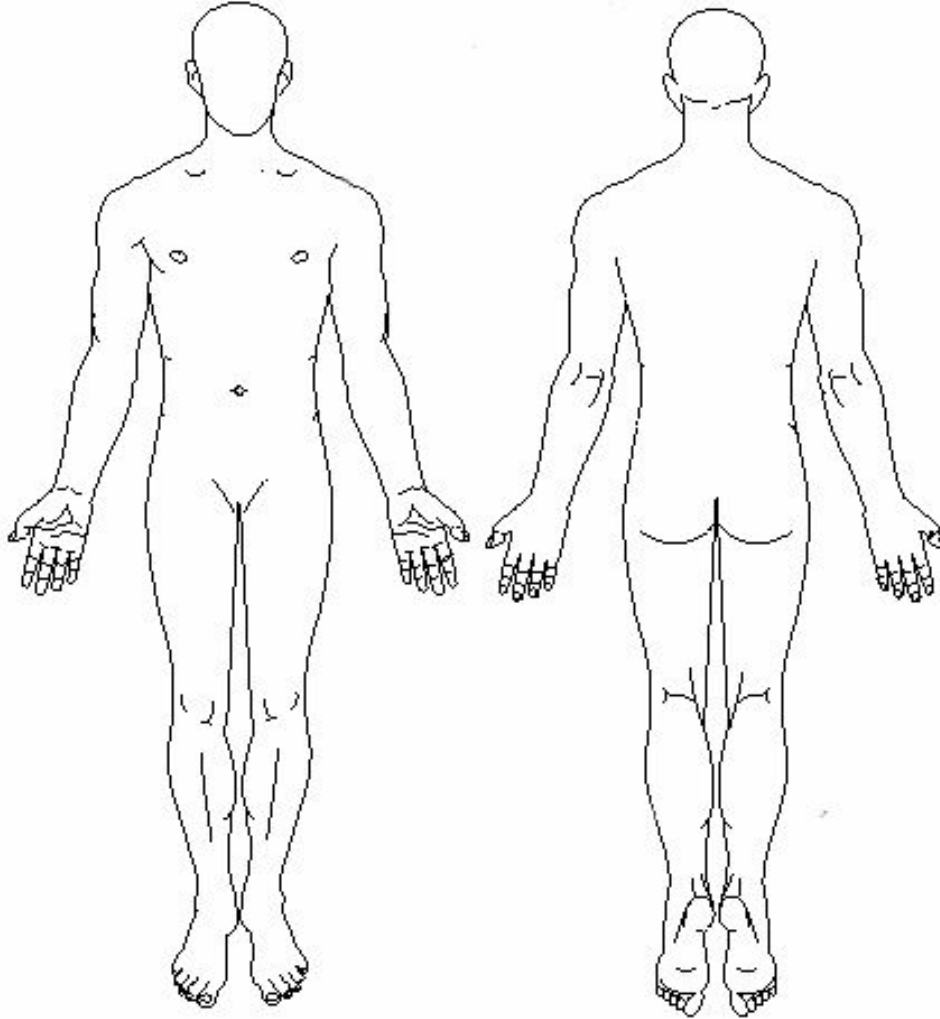
\_\_\_\_\_  
 Signature of Patient (Guardian, if Minor) Date Signature of Witness Date

# PATIENT PAIN PROFILE

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

KEY  
 A = ACHE      N = NUMBNESS      P = PINS & NEEDLES      B = BURNING      S = STABBING  
 O = OTHER (Please describe): \_\_\_\_\_



What percent of the time is your pain present? If your pain is there all the time, in varying degrees, that would indicate 100%.

Rate the intensity of your pain. Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you cannot perform or complete your work, social, or recreational activities.

	<b>Symptom Description</b> <i>Describe each symptom, including area, as clearly as possible.</i>	<b>Frequency</b> <i>Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours</i>	<b>Intensity Range</b> <i>Using a scale of 0-10, where 10 is the worst pain imaginable, rate the pain intensity level for each symptom.</i>
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please Mark "No" or "Yes" For Each Symptom

	No	Yes		No	Yes		No	Yes
<b>Constitutional</b>			<b>Respiratory</b>			<b>Eye</b>		
Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Chest Pain	<input type="radio"/>	<input type="radio"/>	Eye Pain	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>	Failing Vision	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>	Difficulty Breathing	<input type="radio"/>	<input type="radio"/>	Far Sighted	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Spitting Up Blood	<input type="radio"/>	<input type="radio"/>	Near Sighted	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	Spitting Up Phlegm	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	Wheezing	<input type="radio"/>	<input type="radio"/>	Blurred Vision	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>			
Weight Loss	<input type="radio"/>	<input type="radio"/>				<b>Ears, Nose &amp; Throat</b>	<b>No</b>	<b>Yes</b>
Loss of Sleep	<input type="radio"/>	<input type="radio"/>	<b>Gastrointestinal</b>	<b>No</b>	<b>Yes</b>	Ringing in Ears	<input type="radio"/>	<input type="radio"/>
Night Sweats	<input type="radio"/>	<input type="radio"/>	Excessive Belching	<input type="radio"/>	<input type="radio"/>	Colds	<input type="radio"/>	<input type="radio"/>
			Excessive Gas	<input type="radio"/>	<input type="radio"/>	Deafness	<input type="radio"/>	<input type="radio"/>
<b>Psychiatric</b>	<b>No</b>	<b>Yes</b>	Colitis	<input type="radio"/>	<input type="radio"/>	Earaches	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	Colon Trouble	<input type="radio"/>	<input type="radio"/>	Ear Discharge	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	Ear Noise	<input type="radio"/>	<input type="radio"/>
Mood Swings	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	Enlarged Glands	<input type="radio"/>	<input type="radio"/>
			Difficult Digestion	<input type="radio"/>	<input type="radio"/>	Enlarged Thyroid	<input type="radio"/>	<input type="radio"/>
<b>Musculoskeletal</b>	<b>No</b>	<b>Yes</b>	Bloated Abdomen	<input type="radio"/>	<input type="radio"/>	Gum Trouble	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Excessive Hunger	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>
Bursitis	<input type="radio"/>	<input type="radio"/>	Gallbladder Trouble	<input type="radio"/>	<input type="radio"/>	Hoarseness	<input type="radio"/>	<input type="radio"/>
Foot Trouble	<input type="radio"/>	<input type="radio"/>	Hemorrhoids	<input type="radio"/>	<input type="radio"/>	Nasal Obstruction	<input type="radio"/>	<input type="radio"/>
Hernia	<input type="radio"/>	<input type="radio"/>	Intestinal Worms	<input type="radio"/>	<input type="radio"/>	Nose Bleeds	<input type="radio"/>	<input type="radio"/>
Neck Pain	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>	Sinus Infections	<input type="radio"/>	<input type="radio"/>
Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Liver Trouble	<input type="radio"/>	<input type="radio"/>	Sore Throat	<input type="radio"/>	<input type="radio"/>
Low Back Pain	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>			
Fractures	<input type="radio"/>	<input type="radio"/>	Stomach Pain	<input type="radio"/>	<input type="radio"/>	<b>Genitourinary</b>	<b>No</b>	<b>Yes</b>
			Poor Appetite	<input type="radio"/>	<input type="radio"/>	Blood in Urine	<input type="radio"/>	<input type="radio"/>
<b>Cardiovascular</b>	<b>No</b>	<b>Yes</b>	Vomiting	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>
Hardening of Arteries	<input type="radio"/>	<input type="radio"/>	Vomiting of Blood	<input type="radio"/>	<input type="radio"/>	Kidney Infection	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>				Painful Urination	<input type="radio"/>	<input type="radio"/>
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	<b>Skin</b>	<b>No</b>	<b>Yes</b>	Prostate Trouble	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Poor Circulation	<input type="radio"/>	<input type="radio"/>	Dryness	<input type="radio"/>	<input type="radio"/>	Are You Pregnant?	<input type="radio"/>	<input type="radio"/>
Rapid Heartbeat	<input type="radio"/>	<input type="radio"/>	Hives / Allergy	<input type="radio"/>	<input type="radio"/>			
Slow Heartbeat	<input type="radio"/>	<input type="radio"/>	Itching	<input type="radio"/>	<input type="radio"/>	<b>Neurological</b>	<b>No</b>	<b>Yes</b>
Swelling of Ankles	<input type="radio"/>	<input type="radio"/>	Varicose Veins	<input type="radio"/>	<input type="radio"/>	Tremors	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>	Skin Eruptions (Rash)	<input type="radio"/>	<input type="radio"/>	Fainting Spells	<input type="radio"/>	<input type="radio"/>
						Coordination Difficulty	<input type="radio"/>	<input type="radio"/>

## SURGERIES / OPERATIONS

YEAR	BODY REGION	PROCEDURE
1.		
2.		
3.		
4.		
5.		
6.		

## ***FAMILY HISTORY***

**Please mark relative's current age or age at time of death.**

Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (Describe)	
Father																			
Mother																			
Brothers & Sisters	#1																		
	#2																		
	#3																		
	#4																		
	#5																		

## ***PRIOR AUTO ACCIDENTS / WORK INJURIES***

YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT
1.			
2.			
3.			
4.			
5.			
6.			

## ***MEDICAL ILLNESSES***

**List current and past illnesses not mentioned above, including cancer, diabetes, depression, thyroid, heart disease, blood pressure, etc.**

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

## ***PRIMARY CARE PHYSICIAN***

NAME: \_\_\_\_\_ LAST PHYSICAL EXAM: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>HABITS:</b>	Yes	No	<i>If yes, please describe:</i>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: <input type="checkbox"/> 1/2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 or more How long? _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ or # Drinks per week _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Type _____

**HANDEDNESS:**  Right-handed  Left-handed  Ambidextrous

**MEDICATIONS:** Please list all currently used medications. Include prescription and non-prescription drugs.

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**ALLERGIES:** Please list all known allergies, especially to medications.

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**TREATMENT YOU ARE RECEIVING OR HAVE RECEIVED FOR THIS CONDITION:**

Medical care \_\_\_\_\_

Chiropractic care \_\_\_\_\_

Physical Therapy \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

**DOCTOR'S NOTES:**

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **MOTOR VEHICLE COLLISION QUESTIONNAIRE**

Date of Accident: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

### **Questions about the accident circumstances**

Year and Make of vehicle you were riding in: \_\_\_\_\_

Number of other vehicles involved \_\_\_\_\_

Year and Make of other vehicle(s):

Vehicle #2 \_\_\_\_\_

Vehicle #3 \_\_\_\_\_

Monetary damage to your vehicle: \$ \_\_\_\_\_

Was there damage to other vehicles? \_\_\_\_\_

Your head rest was adjusted to:

Top of Shoulder: \_\_\_\_\_

Top of Ear: \_\_\_\_\_

Top of Head: \_\_\_\_\_

Were you the driver or passenger?

Driver  Passenger

If passenger, where were you seated?

- Passenger's seat
- Rear seat, driver's side
- Rear seat, passenger's side

Were you wearing a seat belt at the time?  Yes  No

Was your vehicle moving or stopped?  Moving  Stopped

Did your vehicle strike another vehicle?  Yes  No

Did another vehicle strike yours?  Yes  No

Where was your vehicle hit?

- In the front
- In the rear
- On the driver's side
- On the passenger's side

Describe the collision: \_\_\_\_\_

\_\_\_\_\_

If your vehicle had airbags, did they deploy?  Yes  No

What were the road conditions?

- Dry
- Wet
- Icy
- Snow-packed
- Other, describe \_\_\_\_\_

How far did your car move after impact?

Car lengths \_\_\_\_\_

Feet \_\_\_\_\_

### **Questions about your circumstances at impact**

Were you aware of the impending impact?  Yes  No

If yes, did you brace yourself before the impact?  Yes  No

Were you looking in a mirror?  Yes  No

If yes, please describe: \_\_\_\_\_

What was your body position at time of impact?

- Neutral
- Forward
- Rotated: Left/Right

Did you strike another object?

- Steering wheel
- Dash
- Window
- Other \_\_\_\_\_

Did you experience any of the following at the time of impact?

- Cuts  Abrasions, where? \_\_\_\_\_
- Bruises  Dislocations
- Bumps  Immediate dizziness
- Nausea  Altered consciousness
- Immediate head pain
- Vision problems
- Immediate pain, where? \_\_\_\_\_
- Loss of consciousness, how long? \_\_\_\_\_

### **Questions about your circumstances after the accident**

Were you able to get out of the vehicle and walk on your own?  Yes  No

Was your car drivable from scene of accident?  Yes  No

Where did you go after the accident?

- Home
- Work
- Hospital

Were you taken by ambulance?  Yes  No  
Where? \_\_\_\_\_

Who was at fault for this accident? \_\_\_\_\_

Did the police write any tickets?  Yes  No  
To whom? \_\_\_\_\_

If you went to a hospital, did you stay overnight?  Yes  No

If you went to a hospital, were any x-rays taken?  Yes  No

If x-rays were taken, what areas of your body were x-rayed?  
\_\_\_\_\_

How did you feel that night?

- Restless  Stiff  Fine
- In pain  Sore

How did you feel the next day?

- Better  Same  Worse

Have you missed any time from work?  Yes  No  
How Much? \_\_\_\_\_

## **PATIENT TREATMENT HISTORY**

**LIST ALL DOCTORS, TESTS, AND TREATMENT YOU HAVE RECEIVED SINCE YOUR INJURY**

Start with the first doctor/healthcare provider/hospital you saw after your injury and check all tests/treatments that apply

1. Name of hospital/doctor/therapist/medical center:

Date of visit:

Indicate what was done by checking the appropriate boxes:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Exam Consultation     | <input type="checkbox"/> Rehabilitation        | <input type="checkbox"/> Spinal manipulation/adjustments          |
| <input type="checkbox"/> X-ray of neck         | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Muscle massage/myotherapy                |
| <input type="checkbox"/> X-ray of lower back   | <input type="checkbox"/> Exercise recommended  | <input type="checkbox"/> Heat packs                               |
| <input type="checkbox"/> Other x-rays          | <input type="checkbox"/> Medication prescribed | <input type="checkbox"/> Cold/ice packs                           |
| <input type="checkbox"/> MRI/CT scan           | <input type="checkbox"/> Neck collar           | <input type="checkbox"/> Ultrasound/Electrical muscle stimulation |
| <input type="checkbox"/> Other diagnostic test | <input type="checkbox"/> Low back brace        | <input type="checkbox"/> Other, <i>describe below</i> :           |

Indicate if treatment:

- Made condition worse  
 Did not help  
 Helped

2. Name of hospital/doctor/therapist/medical center:

Date of visit:

Indicate what was done by checking the appropriate boxes:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Exam Consultation     | <input type="checkbox"/> Rehabilitation        | <input type="checkbox"/> Spinal manipulation/adjustments          |
| <input type="checkbox"/> X-ray of neck         | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Muscle massage/myotherapy                |
| <input type="checkbox"/> X-ray of lower back   | <input type="checkbox"/> Exercise recommended  | <input type="checkbox"/> Heat packs                               |
| <input type="checkbox"/> Other x-rays          | <input type="checkbox"/> Medication prescribed | <input type="checkbox"/> Cold/ice packs                           |
| <input type="checkbox"/> MRI/CT scan           | <input type="checkbox"/> Neck collar           | <input type="checkbox"/> Ultrasound/Electrical muscle stimulation |
| <input type="checkbox"/> Other diagnostic test | <input type="checkbox"/> Low back brace        | <input type="checkbox"/> Other, <i>describe below</i> :           |

Indicate if treatment:

- Made condition worse  
 Did not help  
 Helped

3. Name of hospital/doctor/therapist/medical center:

Date of visit:

Indicate what was done by checking the appropriate boxes:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Exam Consultation     | <input type="checkbox"/> Rehabilitation        | <input type="checkbox"/> Spinal manipulation/adjustments          |
| <input type="checkbox"/> X-ray of neck         | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Muscle massage/myotherapy                |
| <input type="checkbox"/> X-ray of lower back   | <input type="checkbox"/> Exercise recommended  | <input type="checkbox"/> Heat packs                               |
| <input type="checkbox"/> Other x-rays          | <input type="checkbox"/> Medication prescribed | <input type="checkbox"/> Cold/ice packs                           |
| <input type="checkbox"/> MRI/CT scan           | <input type="checkbox"/> Neck collar           | <input type="checkbox"/> Ultrasound/Electrical muscle stimulation |
| <input type="checkbox"/> Other diagnostic test | <input type="checkbox"/> Low back brace        | <input type="checkbox"/> Other, <i>describe below</i> :           |

Indicate if treatment:

- Made condition worse  
 Did not help  
 Helped

4. Name of hospital/doctor/therapist/medical center:

Date of visit:

Indicate what was done by checking the appropriate boxes:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Exam Consultation     | <input type="checkbox"/> Rehabilitation        | <input type="checkbox"/> Spinal manipulation/adjustments          |
| <input type="checkbox"/> X-ray of neck         | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Muscle massage/myotherapy                |
| <input type="checkbox"/> X-ray of lower back   | <input type="checkbox"/> Exercise recommended  | <input type="checkbox"/> Heat packs                               |
| <input type="checkbox"/> Other x-rays          | <input type="checkbox"/> Medication prescribed | <input type="checkbox"/> Cold/ice packs                           |
| <input type="checkbox"/> MRI/CT scan           | <input type="checkbox"/> Neck collar           | <input type="checkbox"/> Ultrasound/Electrical muscle stimulation |
| <input type="checkbox"/> Other diagnostic test | <input type="checkbox"/> Low back brace        | <input type="checkbox"/> Other, <i>describe below</i> :           |

Indicate if treatment:

- Made condition worse  
 Did not help  
 Helped

## CONSENT FORM FOR CHIROPRACTIC MANIPULATION/MOBILIZATION

Manipulation/mobilization helps restore proper motion to the vertebral (facet) joints. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to reestablish proper function to the spine and to reduce pain, edema and muscle spasm. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint.

### *Possible Risks:*

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to intervertebral discs, nerves or spinal cord. Stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Your chiropractor may also use modalities to enhance your recovery and reduce symptoms. These may include ultrasound, electrical modalities, laser therapy, heat and ice, and other modalities. These are rarely associated with side effects or complications, and the risks may include soreness, skin reactions, or other mild side effects. Please report these and any other side effects or complications to your doctor right away. If you have skin sensitivities, a pacemaker, pregnancy or any other health condition that would change your ability to be exposed to electrical modalities, topical creams, or other care restrictions, please advise your doctor immediately.

I, \_\_\_\_\_, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanation to my questions. My signature below authorizes this procedure.

\_\_\_\_\_  
*Patient/Authorized Representative Signature*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Date*



## **DOCTOR'S LIEN**

Attorney's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Provider:            *Advanced Spine & Rehabilitation*  
                          *715 Mall Ring Circle, Suite 205*  
                          *Henderson, NV 89014*  
                          *Phone: (702) 990-2225*  
                          *Fax: (702) 990-7711*  
                          *E-mail: advancedspinerehab@yahoo.com*

I hereby authorize *Advanced Spine & Rehabilitation* to furnish you, my attorney, with a full report and records regarding case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my accident, which occurred on \_\_\_\_\_.  
(date of incident)

I hereby give a lien and assignment to *Advanced Spine & Rehabilitation* on the proceeds or any settlement, claim, judgment, or verdict which results from said incident. I further authorize, direct, and instruct you, my attorney, to pay directly to *Advanced Spine & Rehabilitation* such sums as may be due and owing for service rendered me by reason of this incident and by reason of any other bills that are due, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect *Advanced Spine & Rehabilitation* adequately and such sums as may be necessary to fully and completely pay *Advanced Spine & Rehabilitation* any outstanding balance owed at the time of distribution of funds from any settlement, claim, judgment, or verdict.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I also agree not to request a fee reduction regardless of the amount of total settlement. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon this case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to *Advanced Spine & Rehabilitation* for all bills submitted by *Advanced Spine & Rehabilitation* for services rendered to me, and that this agreement is made solely for additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

To My Attorney: I direct that you be bound by this lien and treat it, irrevocably, as an assignment to *Advanced Spine & Rehabilitation* of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that *Advanced Spine & Rehabilitation* is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing health care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that *Advanced Spine & Rehabilitation* be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to *Advanced Spine & Rehabilitation* to comply with the terms of this direction to you.

\_\_\_\_\_  
*Patient's Signature*

\_\_\_\_\_  
*Date*

## ***FINANCIAL POLICY***

Welcome to our office! We are pleased that you have chosen Advanced Spine & Rehabilitation to provide your care and services. We would like to take a moment to inform you of our policies, regarding payment with the office. We accept cash, personal checks and credit card (VISA, MasterCard, or Discover) for payment on your account.

**INSURANCE PATIENTS WHO NEGLECT TO SUPPLY THIS OFFICE  
WITH THE NECESSARY INFORMATION/FORMS  
WITHIN A REASONABLE AMOUNT OF TIME  
WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

**AUTO/PERSONAL INJURY INSURANCE** (PIP, Med-Pay, 3<sup>rd</sup> Party, Lien) or **WORKER'S COMPENSATION:** You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

**CONTRACTED INSURANCE** (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, and address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service, and any amounts not covered by your insurance, including deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for payment of the entire balance due, based on our normal fee schedule. *You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you reschedule or sign a waiver for no referral or authorization thus holding you financially responsible.*

**PRIVATE INSURANCE:** As a courtesy, we are happy to file your insurance for you. You will be required to provide all the necessary billing information. *If you owe on your deductible or a co-insurance, we will need to collect at the time of service.* All insurance payments that are paid directly to you should be endorsed and paid to Advanced Spine & Rehabilitation. It is your responsibility to contact your insurance in the event of non-payment.

**MEDICARE:** We are participating with the Medicare program. *We will submit your claim/services to Medicare. Medicare will process payment to us.* You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us.

**CASH ONLY PLAN/NO INSURANCE:** *Payment in full is due the day services are rendered* by all patients on a cash only plan. *Prompt payment is expected.* Unless prior arrangements are made, overdue accounts will incur a 1.5% interest rate per month, plus reasonable collection fees.

*I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Advanced Spine & Rehabilitation.*

\_\_\_\_\_  
*Patient's Signature (Responsible party over 18 years old)*

\_\_\_\_\_  
*Date*

**NOTICE TO INSURANCE COMPANY ASSIGNMENT**

**PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY**

Date: \_\_\_\_\_

Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Pay to: *Advanced Spine & Rehabilitation  
715 Mall Ring Circle, Suite 205  
Henderson, NV 89014  
Phone: (702) 990-2225  
Fax: (702) 990-7711  
E-mail: [advancedspinerehab@yahoo.com](mailto:advancedspinerehab@yahoo.com)*

You are instructed to pay directly to the doctor and/or Advanced Spine & Rehabilitation, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/office. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment.

I hereby authorize the doctor/office listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Signature:            **X** \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Witness: \_\_\_\_\_

## ***PATIENT CONSENT FORM***

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

*Date:* \_\_\_\_\_

*Patient Name (print):* \_\_\_\_\_

*Relationship to patient:* \_\_\_\_\_

*Signature:* \_\_\_\_\_