W E L C O M E !

CONFIDENTIAL PATIENT INFORMATION

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* ❒ *Part-time* Work Status: ❒ *Working without restrictions* ❒ *Working with restrictions* ❒ *Not working/off work since*_____ ❒ *Retired*
Employer: _____ Occupation: _____

Job Description: _____ Years Employed: _____

Address: _____
Street Address/P.O. Box *City* *State* *Zip*

_____

Date of injury, surgery, or onset of symptoms:_____
What type of injury are we seeing you for?
❒ *Auto* ❒ *Sports Injury* ❒ *No specific trauma*
❒ *Work* ❒ *Slip & Fall* ❒ *Other*

Emergency Contact, not living with you:
Name: _____
Phone #:_____ Relationship: _____

☑ ***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

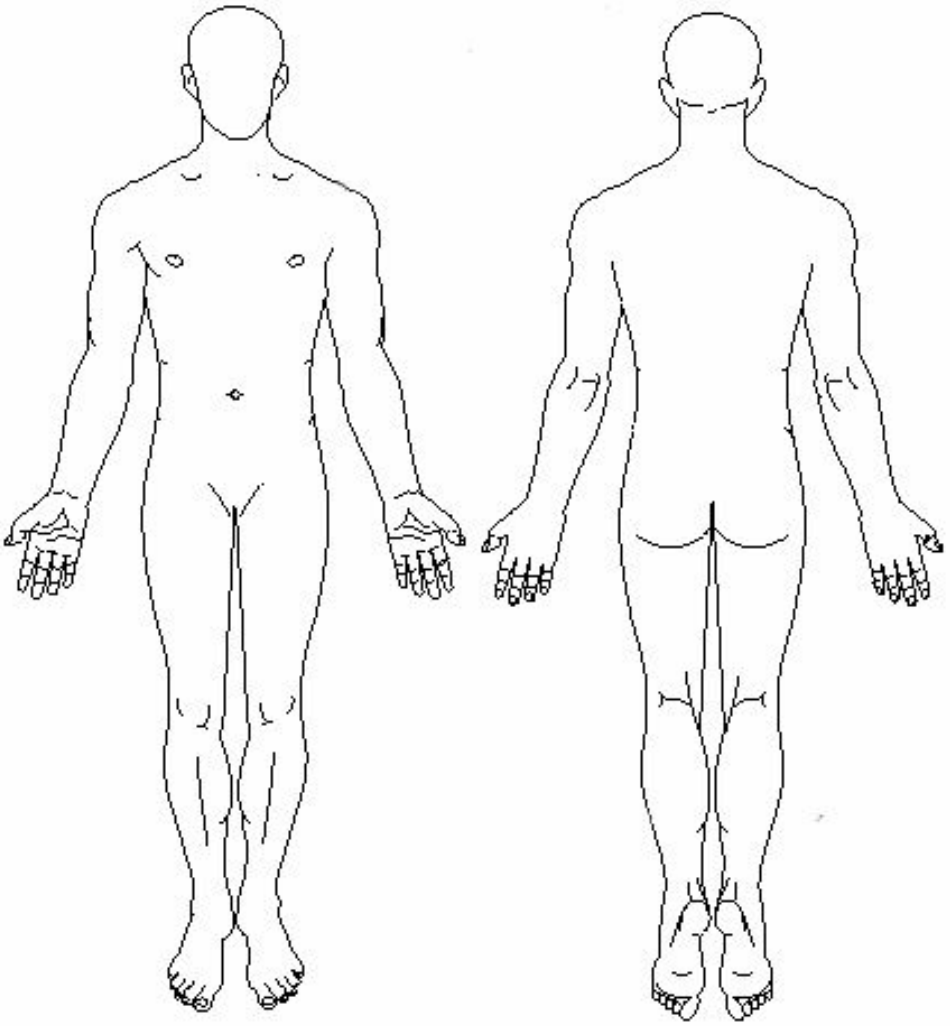
Patient Name: _____ **Date:** _____

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.

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

Patient Name: _____ **Date**:_____

REVIEW OF SYSTEMS

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

Constitutional	**No**	**Yes**
Excessive Thirst	O	O
Chills	O	O
Convulsions	O	O
Dizziness	O	O
Fainting	O	O
Fatigue	O	O
Fever	O	O
Weight Loss	O	O
Loss of Sleep	O	O
Night Sweats	O	O
Psychiatric	**No**	**Yes**
Nervousness	O	O
Depression	O	O
Mood Swings	O	O
Musculoskeletal	**No**	**Yes**
Arthritis	O	O
Bursitis	O	O
Foot Trouble	O	O
Hernia	O	O
Neck Pain	O	O
Mid Back Pain	O	O
Low Back Pain	O	O
Fractures	O	O
Cardiovascular	**No**	**Yes**
Hardening of Arteries	O	O
High Blood Pressure	O	O
Low Blood Pressure	O	O
Chest Pain	O	O
Poor Circulation	O	O
Rapid Heartbeat	O	O
Slow Heartbeat	O	O
Swelling of Ankles	O	O
Other:	O	O

Respiratory	**No**	**Yes**
Chest Pain	O	O
Chronic Cough	O	O
Difficulty Breathing	O	O
Spitting Up Blood	O	O
Spitting Up Phlegm	O	O
Wheezing	O	O
Asthma	O	O
Gastrointestinal	**No**	**Yes**
Excessive Belching	O	O
Excessive Gas	O	O
Colitis	O	O
Colon Trouble	O	O
Constipation	O	O
Diarrhea	O	O
Difficult Digestion	O	O
Bloated Abdomen	O	O
Excessive Hunger	O	O
Gallbladder Trouble	O	O
Hemorrhoids	O	O
Intestinal Worms	O	O
Jaundice	O	O
Liver Trouble	O	O
Nausea	O	O
Stomach Pain	O	O
Poor Appetite	O	O
Vomiting	O	O
Vomiting of Blood	O	O
Skin	**No**	**Yes**
Bruise Easily	O	O
Dryness	O	O
Hives / Allergy	O	O
Itching	O	O
Varicose Veins	O	O
Skin Eruptions (Rash)	O	O

Eye	**No**	**Yes**
Eye Pain	O	O
Failing Vision	O	O
Far Sighted	O	O
Near Sighted	O	O
Glaucoma	O	O
Blurred Vision	O	O
Ears, Nose & Throat	**No**	**Yes**
Ringing in Ears	O	O
Colds	O	O
Deafness	O	O
Earaches	O	O
Ear Discharge	O	O
Ear Noise	O	O
Enlarged Glands	O	O
Enlarged Thyroid	O	O
Gum Trouble	O	O
Hay Fever	O	O
Hoarseness	O	O
Nasal Obstruction	O	O
Nose Bleeds	O	O
Sinus Infections	O	O
Sore Throat	O	O
Genitourinary	**No**	**Yes**
Blood in Urine	O	O
Frequent Urination	O	O
Kidney Infection	O	O
Painful Urination	O	O
Prostate Trouble	O	O
Seizures	O	O
Are You Pregnant?	O	O
Neurological	**No**	***Yes***
Tremors	O	O
Fainting Spells	O	O
Coordination Difficulty	O	O

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: _____

HABITS:

	Yes	No	*If yes, please describe*:
Smoking	❒	❒	*Packs per day:* ❒ *0 – ½* ❒ *½ - 1* ❒ *2 or more* *How long?* _____
Alcohol Consumption	❒	❒	*# Drinks per day* _____ *# Drinks per week* _____
Other Drug Use (Street Drugs)	❒	❒	_____
Exercise	❒	❒	❒ *Daily* ❒ *Weekly* ❒ *Monthly* *Type* _____

HANDEDNESS: ❒ Right-handed ❒ Left-handed ❒ Ambidextrous

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

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

TREATMENT YOU ARE RECEIVING OR HAVE RECEIVED FOR THIS CONDITION:

❒ *Medical care* _____

❒ *Chiropractic care* _____

❒ *Physical Therapy* _____

❒ *Other* _____

❒ *Other* _____

DOCTOR'S NOTES:

_____

_____

_____

_____

_____

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:

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

   _____

   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:

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

   _____

   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:

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

   _____

   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:

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

   _____

   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 senstitivies, 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*

Practitioner Statement:

The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

_____	_____	_____
Practitioner Signature	*Practitioner Printed Name*	*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, 3rd 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

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: _____