CONFIDENTIAL PATIENT INFORMATION

WELCOME

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*

Whom may we thank for referring you? ______________________

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 Name: ______________________________ **Date:** ______________

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																			

HOSPITALIZATIONS, OPERATIONS, AUTOMOBILE & ON THE JOB INJURIES

Please be as specific as possible, INCLUDING AREAS INVOLVED, EVALUATIONS, TREATMENT, AND YEAR

1.
2.
3.
4.
5.
6.

SERIOUS 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.

TESTS

Please list the MOST RECENT date.

Chest X-ray ____________ EKG ______________ Other X-ray ____________ MRI/ CT Scans ____________

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* ________
Coffee or Tea Consumption	❐	❐	*# Cups per day* ________
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 drug.*

____

____

____

____

____

____

____

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 PAIN PROFILE

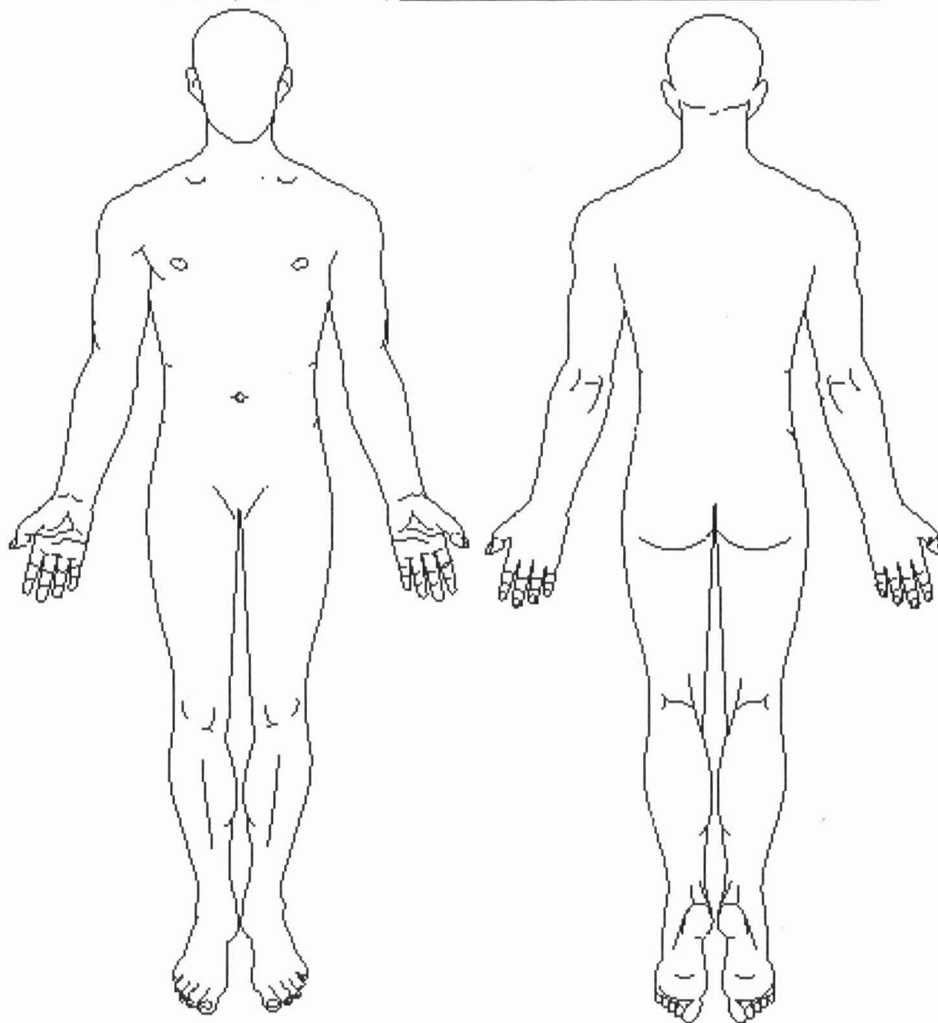
Patient Name: ______________________________ **Date:** ______________

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.

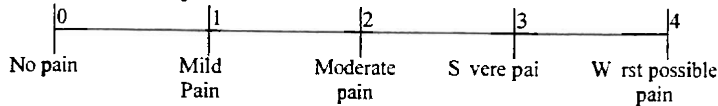
	Symptom Description *Describe each symptom, including area, as clearly as possible.*	**Frequency** *Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours*	**Intensity Range** *Using a scale of 0-10, where 10 is the worst pain imaginable, rate the pain intensity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

Functional Rating Index

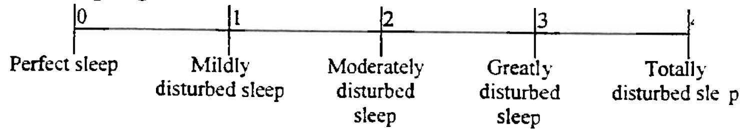
For use with **Neck and/or Back Problems** only

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, pleas circle the number that most closely describes your condition right now.

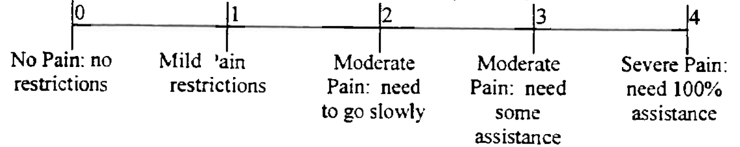
1. Pain Intensity



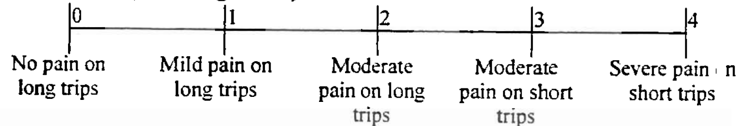
2. Sleeping



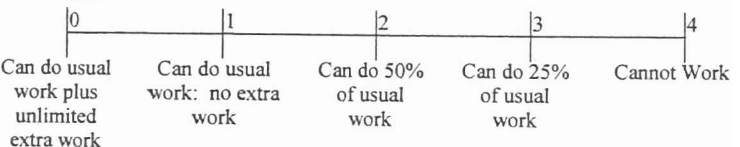
3. Personal Care (washing, dressing, etc.)



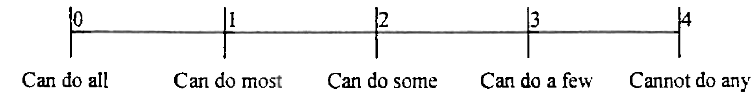
4. Travel (driving, etc.)



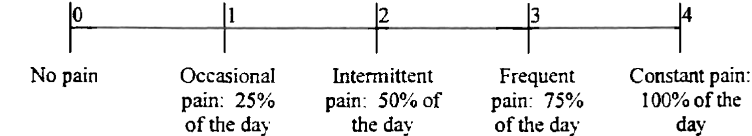
5. Work



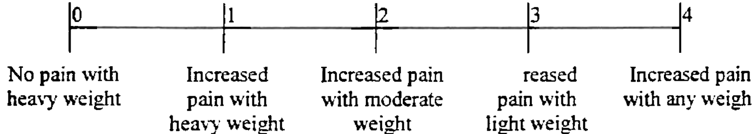
6. Recreation



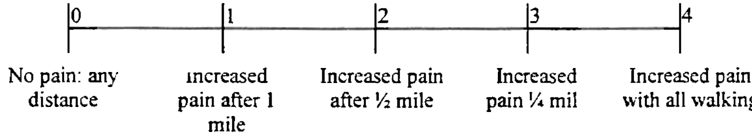
7. Frequency of Pain



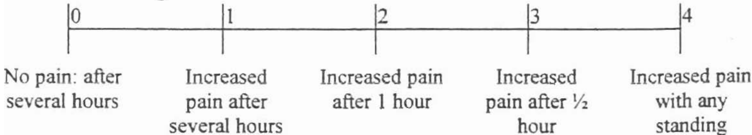
8. Lifting



9. Walking



10. Standing



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 and MasterCard) 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 to be seen in our office. If you do not have a current referral, we ask that you reschedule or sign a waiver for no referral 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*

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: ____

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: $______________

Monetary 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 impact: ______________

____

____

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

Did you see the 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 your complaints kept you from doing anything? ❒ Yes ❒ No

What? ______________

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

   Indicate if treatment:
   - ❒ Made condition worse
   - ❒ Did not help
   - ❒ Helped

Advanced Spine & Rehabilitation

Specializing in Neuromusculoskeletal Conditions

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Fax: (702) 990-7711

Reno, NV
1875 Plumas St., Ste 5
Reno, Nevada 89509
Phone: (888) 825-3768
Fax: (702) 990-7711

Carson City, NV
200 W. Long St.
Carson City, Nevada 89703
Phone: (888) 825-3768
Fax: (702) 990-7711

Mesquite, NV
1301 Bertha Howe Ave., Ste 7
Mesquite, Nevada 89027
Phone: (888) 825-3768
Fax: (702) 990-7711

St. George, UT
1812 W. Sunset Blvd, Ste 18
St. George, UT 84770
Phone: (435) 656-0234
Fax: (435) 656-2622

Provider Lien

Attorney:
Name: ________________________________
Address: ______________________________
____
____

RE: ____________________________
DOI: ___________________________
CLAIM: _________________________

I, the undersigned acknowledge that I am indebted to Advanced Spine & Rehabilitation for chiropractic services, rehabilitation services and supplies rendered.

I further acknowledge that I have a personal injury action pending. Wherefore, I hereby grant Advanced Spine & Rehabilitation a lien as to any proceeds that become available from said personal injury action and hereby instruct my attorney to pay the same to Advanced Spine & Rehabilitation. The proceeds mean that all funds resulting from my claim after reduction of costs attorney's fees as provided by the contingent fee agreement between me and my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien inherent to the settlement and enforceable upon the case as if it were executed by the new attorney.

I understand that I am directly and fully responsible to Advanced Spine & Rehabilitation for all chiropractic bills submitted for services rendered me and that this agreement is solely for said health care providers' additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict.

DATED: _______________ *GUARANTOR:* __________________________

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict available after reduction of all attorney's fees and costs as provided by the attorney's contingent fee agreement between attorney and client.

DATED: ______________ *ATTORNEY:* _____________________________

Doctor Signature: ____