Spinal Care Associates

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we can begin any health care treatment we need you to read and sign this consent stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chiropractic office to use their Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PHI of the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractic Physician has the right to refuse given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient/Parent or Guardian Date

Pertinent Data

Patient's Attorney Information

Attorney Name: _____ Firm: _____

Telephone #: _____ Fax #: _____

Address: _____

MED PAY Information

Patient's Auto Insurance Company: _____

Address: _____

Insured: _____ Adjustor: _____

Telephone #: _____ Fax #: _____

Policy #: _____ Claim #: _____

Third Party Insurance Information

Insurance Company: _____

Address: _____

Insured: _____ Adjustor: _____

Telephone #: _____ Fax #: _____

Policy #: _____ Claim #: _____

Release of Information

I give Spinal Care Associates permission to talk to the following people about my records/treatment (please print):

Name	Relationship to Patient	Best Contact Number

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

Authorization and Assignment of Benefits

1. You are to release any information you deem appropriate concerning my health condition to an insurance company, attorney or adjuster in order to process any claim for reimbursement of charges to the doctor and/or clinic by me.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you in part upon the charges made for services.

3. I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment.

4. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that when all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

5. I waiver the statute of limitations regarding my doctor's right to recover.

Signed: _____ Date: _____

Witness: _____ Date: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: _____ Date of Birth: _____Today's Date: _____

1. Date of Accident: _____ Time: _____ A.M./P.M.

2. Describe the collision in your own words: _____

_____

_____

_____

3. In what city/town and state did the accident occur? _____

4. Where were you seated? ☐Driver ☐Front Passenger ☐Rear Passenger (Right/Left/Center)

5. Who was the driver? (If not you): _____

6. What type of vehicle were you in? (Make & Model): _____

7. What type was the other vehicle? (Make & Model): _____

8. Was your vehicle initially struck by another vehicle? ☐ Yes ☐ No

9. Did your vehicle initially strike the other vehicle? ☐Yes ☐ No

10. What was your collision with? ☐ Another Vehicle ☐ Motorcycle ☐ Tree
☐ Guardrail ☐ Pedestrian

11. What type of collision? ☐ Rear-End Collision ☐ Passenger-Side ☐ Driver-Side
☐ Head- On ☐ Front-End ☐Other: _____

12. How fast were you driving? _____ MPH ☐Stopped

13. How fast was the other vehicle driving? _____ MPH ☐Stopped

14. What were the road conditions like? ☐Dry ☐ Wet ☐ Snowy ☐ Icy/Slick

15. What was the visibility at the time of the accident? ☐Good ☐Fair ☐ Poor

16. What was the weather like? ☐ Sunny ☐Raining ☐Snowing ☐ Dark

17. Were you wearing a seatbelt? ☐ Yes ☐ No

18. Where were you looking at the time of impact? ☐ Straight Ahead ☐ To the Right
☐ To the Left ☐ Down ☐Up ☐Backwards ☐ Rearview Mirror

19. Were you surprised by the impact? ☐Yes ☐No

20. Were you braced for the impact? ☐Yes ☐No

21. Did your seat have a head rest? ☐ Yes ☐ No ☐Not Sure

22. Did any part of your body hit the interior of the vehicle? ☐Yes ☐ No ☐Not Sure

If yes, which body part? _____

What did the body part hit? _____

23. How did you feel immediately after the accident? ☐ Stunned ☐Dazed ☐Confused

☐ Disoriented ☐ Other: _____

24. Did you have pain immediately after the accident? ☐ Yes ☐No

If yes, where? _____

25. Did you lose consciousness? ☐Yes ☐ No If yes, for how long? _____

26. Was your vehicle drivable after the accident? ☐ Yes ☐No

If no, how did you leave the accident? _____

27. Did you go to the hospital? ☐Yes ☐ No If yes, when? _____

How did you get to the hospital? ☐ Ambulance ☐Other: _____

Did you have any X-Rays, CT Scans or MRI's taken? ☐ Yes ☐No

Were any medications or medical supplies prescribed to you? ☐Yes ☐No

If yes, what? _____

28. Have you miss any time from work as a result of this accident? ☐Yes ☐No

If yes, how long? _____

29. Do you have an attorney handling this case? ☐Yes ☐No

If yes, please list name, address and phone number: _____

_____

_____

Confidential Patient Data

Today's Date:

Patient Information

Patient's Last Name: First: MI:	Nickname:	Date of Birth:	Sex: ☐ M ☐ F

Social Security Number:	Marital Status: Single Married Divorced Widowed Other

Address:	City:	State:	Zip Code:

Home Phone:	Work Phone:	Cell Phone:	Preferred Phone: ☐Home ☐Work ☐Cell

E-Mail Address:	Employer:

Emergency Contact Name & Phone Number:

Emergency Contact Address:

Primary Care Physician

Primary Care Physician's Name:	Phone & Location:

Other Patient Information

Referred By:

Current Medications:

1. Drug Name: _____ 2. Drug Name: _____
Frequency (e.g. once daily):_____ Frequency (e.g. once daily):_____

3. Drug Name:_____ 4. Drug Name:_____
Frequency (e.g. once daily):_____ Frequency (e.g. once daily):_____

Smoking Status: ☐Current Every Day ☐ Current Some Days ☐ Former ☐Never Start Year: _____ Quit Date:_____

Alcohol Use: ☐ None ☐ Light ☐ Moderate ☐ Heavy	Recreational Drug Use: ☐ None ☐ Light ☐ Moderate ☐ Heavy	Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy

Authorization for Release of Information

For consideration which I acknowledge, I grant to Spinal Care Associates the right to use my name, image, video and audio for marketing materials such as, but not limited to, Spinal Care Associates' website, Facebook and Instagram.

☐ Yes ☐ No

Signature: _____ Date:_____

Family History

Please indicate which conditions exist or have existed by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Son	Daughter
Arthritis	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stomach/Intestinal Disorders	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐
Neurological Disorders	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Psychological/Mental Disorders	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Other Patient Conditions	☐	☐	☐	☐	☐	☐	☐
Unknown Conditions	☐	☐	☐	☐	☐	☐	☐

Comments/Explanations for any conditions marked above:

Please list any previous surgeries:

Please list your symptoms/pain from WORST to LEAST:

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

Please use **ONE PAGE FOR EACH** symptom or complaint
Symptom # _____ (Please select a symptom from the previous page)

Complaint/Symptom:

Rate your pain when it is at its WORST (1-10, 10 being the worst):
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please list any activities impaired by the pain/discomfort (Example: Lifting Children, House Work, Driving, etc.):

Pain Quality:
- ☐ None
- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Diffuse
- ☐ Numbness
- ☐ Radiating
- ☐ Sharp
- ☐ Shooting
- ☐ Stiffness
- ☐ Tight
- ☐ Tingling

Pain Frequency:
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional
- ☐ Never

Pain Radiates Into:
- ☐ None
- ☐ Left Shoulder
- ☐ Left Arm
- ☐ Left Hand
- ☐ Left Leg
- ☐ Left Foot
- ☐ Right Shoulder
- ☐ Right Arm
- ☐ Right Hand
- ☐ Right Leg
- ☐ Right Foot
- ☐ Other: _____

Cause of Pain:
- ☐ None
- ☐ A Fall
- ☐ Work Injury
- ☐ Automobile Accident
- ☐ Illness
- ☐ Lifting Injury
- ☐ Unknown
- ☐ Gradual Onset

Pain Pattern:
- ☐ Better in the Morning
- ☐ Better in the Afternoon
- ☐ Better in the Evening
- ☐ Worse in the Morning
- ☐ Worse in the Afternoon
- ☐ Worse in the Evening
- ☐ Consistent/Unchanged

Previous Treatment for this Symptom:
- ☐ Acupuncture
- ☐ Prescription Medication
- ☐ Massage
- ☐ Surgery
- ☐ Over the Counter Medication
- ☐ None of the Above

Pain Duration:
- ☐ _____ Day(s)
- ☐ _____ Week(s)
- ☐ _____ Month(s)
- ☐ _____ Year(s)

Pain Aggravated By:

☐ Bending
☐ Driving
☐ Exercising
☐ Getting up/down
☐ House Work
☐ Increased Activity
☐ Lifting
☐ Looking Down
☐ Lying Down
☐ Overhead Activities
☐ Reaching
☐ Sitting
☐ Sneezing/Coughing
☐ Standing
☐ Walking
☐ None of the Above

Pain Relieved By:

☐ Exercise
☐ Heat
☐ Ice
☐ Lifting
☐ Lying Down
☐ Medication
☐ Resting
☐ Sitting
☐ Standing
☐ Stretching
☐ Walking
☐ None of the Above

Other comments in regards to your symptoms:

Please use **ONE PAGE FOR EACH** symptom or complaint
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- ☐ Right Leg
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- ☐ Looking Down
- ☐ Lying Down
- ☐ Overhead Activities
- ☐ Reaching
- ☐ Sitting
- ☐ Sneezing/Coughing
- ☐ Standing
- ☐ Walking
- ☐ None of the Above

Pain Relieved By:

- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Lifting
- ☐ Lying Down
- ☐ Medication
- ☐ Resting
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ Walking
- ☐ None of the Above

Other comments in regards to your symptoms: