PERSONAL INFORMATION

First name:_____**M.I.**_____**Last Name:**_____**Preferred Name**_____

Address:_____ **City:** _____ **State:**_____ **Zip:**_____

Birthdate:_____/_____/_____ **Age:**_____ **Gender:** Male ____Female____ Unspecified____ **Height**_____**Weight**____

Primary Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

Home Email:_____ **Work Email:**_____

Status: (Check One) ____ Single ____Married____Divorced____Widowed____Separated Children____Yes____No.How many____

Race: _____White _____Black/African American ____Hispanic/Latino _____Asian _____Native American ____Other_____

I choose not to specify _____

Ethnicity: ____Hispanic or Latino _____Not Hispanic or Latino _____ I choose not to specify

Preferred Language: ____ English _____Spanish _____French _____Japanese _____Chinese _____German _____ Other_____

Emergency Contact: (Name, Relationship, Phone #) _____

How were you referred to 919 Spine? ____Patient _____ _____Physician_____

____Facebook ____Instagram _____ Google _____ 919 Spine Website _____Other_____

Primary Physician

First Name_____ Last Name _____

Practice Name **AND** Phone Number_____

Responsible Party if under 18: First Name:_____**Last Name:**_____

Phone Number_____

REASON FOR VISIT

_____Headache _____ Neck Pain _____ Mid Back Pain _____ Lower Back Pain _____Other_____

What caused this complaint(s)? _____

When did this complaint begin? ____/____/_____ For Women ONLY: Are you Pregnant? ____Yes _____No

Which word describes the frequency of discomfort? _____Constant _____Intermittent _____Occasional _____ Rare

Which phrases best describe changes in your discomfort during the day? Select all that apply: _____Worse in the morning
_____Worse in the afternoon _____Worse at night _____It changes with the weather_____ It does not change.

What helps relieve your discomfort? ____Ice ____ Heat ____Medication _____Other _____

What activities are limited by your discomfort? (Select one or more)

____Bending ____Bowel Movements _____Coughing ____Daily Routine ____Driving _____Getting up ____Lifting _____Lying Down

____Pulling _____Pushing ____Reading _____Sitting _____Sleeping ____Sneezing ____Standing ____Turning my Head

____Urination _____Walking ____Working ____ Other (Please Describe) _____

Health History

Prescription Medications

Prescriptions medications take on a regular or ongoing basis:

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Over-The-Counter Medications

Over-The-Counter Medications taken on a regular or ongoing basis:

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Medication: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, Minerals, Herbs, or dietary supplements taken on a regular basis:

Supplement: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Supplement: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Supplement: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Supplement: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Supplement: ______________________Dosage:______ Frequency: Per ____Day ____Week ____Month ____Other
Please Describe_______________________________

Diet and Exercise

Check if you have ever smoked cigars or cigarettes. ____Yes Check if you still smoke. _____ Yes
How much do you smoke? ___Less than one pack per week ____1-2 Packs per week ____1 pack every two days ____1 pack a day ____More than one pack per day.
Check if you drink alcoholic beverages. ____Yes **How many alcoholic beverages do you consume per week?** _____
Check if a physician has ever diagnosed you as an alcoholic. _____Yes
Has your physician ever diagnosed you with any liver-related problems? _____Yes _____No
How many days a week do you exercise? _____

Allergies

Check if a PHYSICIAN has ever diagnosed you with any allergies. ____Yes

Airborne: (please check all that apply)

___Animal ____Molds/Fungus ____Pollens ____Cat Hair ____Cockroach ____Dog hair ____Dust mites ____Feather Mix ____Guinea Pig Hair ____Other _____

Chemical: (please check all that apply)

____Acetone ____Acetylcholine ____Auto Exhaust ____Benzyl ____Alcohol ____Chlorine ____Citric Acid ____Cologne (all) ____Diesel Exhaust ____Dopamine ____Estradiol ____Ethanol ____Fluorine ____Formaldehyde ____Latex ____Melatonin ____Newspaper Print ____Norepinephrine ____Progesterone ____Propylene ____Serotonin ____Silicone Implant ____Sponge Rubber ____Toluene ____Trichloroethylene ____Wood Pulp ____Xylene ____Other _____

Drug: (please check all that apply)

____Anticonvulsants ____Codeine ____Insulin ____Preparations ____Iodine ____Morphine ____Novocain ____Penicillin ____Sulfa ____Other_____

Surgical History

Check if you have implants, screws, plates or other foreign objects in your body. ____Yes
____Bullet Wound(s) ____Infusion Catheter ____Ear Implant ____Pacemakers ____Eye Implant ____Brain Plate(s) ____Heart Valve(s) ____Shrapnel ____Other _____

Surgeries and/or Hospitalizations (List and DATE):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

YOUR Cancer History

FAMILY Cancer History

(Please list relation- Mother, Father, Sibling, Maternal Grandparent, Paternal Grandparent.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Skin Cancer-(Please list which kind-Basal Cell Carcinoma, Squamous Cell Carcinoma or Melanoma)

YOUR Cardio-Pulmonary/ Circulatory Health

Check if a physician has ever diagnosed you with any of the following:
____Anemia ____HIV/AIDS ____Hemophilia ____Hepatitis ____Hypertension (high blood pressure) ____Hypotension (low blood pressure) ____Hemorrhoids ____ **Lung Disorders**: ____Acute Respiratory Distress Syndrome ____Alpha-1 Antitrypsin Deficiency ____Asbestos/Dust Disease ____Asthma ____Bronchiectasis ____Bronchitis (chronic) ____Bronchopulmonary ____Dysplasia (BPD) ____Chronic Obstructive Pulmonary Disease ____Cystic Fibrosis ____Emphysema ____Farmer's Lung ____Hantavirus ____Histoplasmosis ____Legionellosis ____Lymphangioleiomyomatosis ____Pleurisy ____Pneumonia ____Pneumothorax ____Primary Alveolar ____Hypoventilation Syndrome ____Pulmonary Alveolar Proteinosis ____Pulmonary Embolus ____Pulmonary Fibrosis ____Respiratory Distress Syndrome ____Respiratory Syncytial Virus ____Sarcoidosis ____Severe Acute Respiratory Syndrome ____Spontaneous Pneumothorax ____Tuberculosis ____Raynaud's Phenomenon ____Sickle Cell Anemia ____Sinus Infections (chronic) ____Stroke ____Wegener's Granulomatosis ____Other _____

FAMILY Cardio-Pulmonary/Circulatory Heath

Please list if a **FAMILY** member has ever been diagnosed with the above
List their relation to you-Mother, Father, Sibling, Maternal Grandparent, Paternal Grandparent

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:
____Autoimmune Disorder ____Dermatitis ____Churg-Strauss (Allergic Granulomatosis) ____Eosinophilic Fasciitis ____Dermatomyositis/Polymyositis ____Goodpasture's Syndrome ____Interstitial Granulomatous Dermatitis ____Lupus with Arthritis ____Lupus SLE ____Lupus DLE ____Lupus SCLE ____Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant) ____Mixed Connective Tissue Disease ____Relapsing Polychondritis ____Rheumatoid Arthritis ____Sarcoidosis ____Scleroderma ____Sjogren's Syndrome ____Skin Immunofluorescence ____Vasculitis ____Bladder Disease ____Candida ____Chicken Pox ____Chronic Fatigue Syndrome ____Crohn's Disease ____Diabetes ____Epilepsy ____Fibromyalgia ____Gall Bladder Problems ____Headaches ____Cluster Headaches ____Migraine Headaches ____Sinus Headaches ____Stress-induced Headaches ____Tension Headaches ____Incontinence ____Irritable Bowel Syndrome (IBS) ____Kidney Disease ____Liver Disease ____Liver Problems ____Measles ____Mumps ____Seizures ____Shingles ____Stomach ____Ulcers ____Thyroid Dysfunction ____Urinary Tract Infection ____Other_____

Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition. ____Yes
____Anger Disorders ____Anxiety Disorders ____Asperger Syndrome ____Attention Deficit Disorder with Hyperactivity (ADHD) ____Autistic Disorder ____Avoidant Personality Disorder (AvPD) ____Bipolar Disorder ____Borderline Personality Disorder ____Capgras Syndrome ____Child Behavior Disorders ____Combat Disorders ____Cyclothymic Disorder ____Dependent Personality Disorder (DPD) ____Depressive Disorders (depression) ____Dissociative Disorders ____Dysthymic Disorders (mood disorder) ____Eating Disorders ____Firesetting Behavior ____Hypochondriasis (Somatoform Disorder) ____Impulse Control Disorders

____Kleine-Levin Syndrome ____Kleptomania ____Multiple Personality Disorder ____Munchhausen Syndrome ____Narcissistic ____Personality Disorder ____Narcolepsy ____Obsessive Compulsive Disorder (OCD) ____Phobic Disorders (Phobias) ____Psychotic Disorders ____Restless Legs Syndrome ____Schizophrenia ____Seasonal Affective Disorder ____Sexual or Gender Disorders ____Sexual Dysfunctions (psychological, not physical) ____Sleep Disorders ____Post-traumatic ____Stress Syndrome ____Substance Abuse ____Suicidal Tendencies

Sensory Health

Check if a physician has ever diagnosed you with any of the following:

____Blindness ____Cataract ____Cholesteatoma ____Deafness or Hearing Loss ____Ear ringing ____Eczema ____Glaucoma Laryngitis (chronic) ____Macular Degeneration ____Mumps ____Meniere's Disease ____Nasal ____Polyps ____Perforated Eardrum ____Psoriasis ____Rhinitis ____Sinusitis ____Tinnitus ____Unusual Vision Impairment ____Vertigo ____Other_____

Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

____Arthritis ____Ankylosing ____Spondylitis ____Behets Disease ____Carpal Tunnel Syndrome ____Diffuse Idiopathic Skeletal Hyperostosis (DISH) ____Ehlers-Danlos Syndrome (EDS) ____Felty's Syndrome ____Fibromyalgia ____Infectious Arthritis ____Mixed Connective Tissue Disease (MCTD) ____Osteoarthritis ____Osteoporosis ____Paget's Disease ____Polymyalgia ____Rheumatica ____Polymyositis and Dermatomyositis ____Pseudogout ____Psoriatic Arthritis ____Reactive Arthritis ____Repetitive Stress Injury ____Rheumatoid Arthritis ____Scleroderma ____Sjogren's Syndrome ____Stills Disease ____Gout ____Herniated Disk ____Lyme Disease ____Multiple Sclerosis ____Muscular Dystrophy ____Numbness or Tingling in feet ____Numbness or Tingling in hands ____Osteoporosis ____Parkinson's Disease ____Pinched Nerve ____Polio ____Rheumatism ____Sciatica ____Temporomandibular Joint Syndrome (TMJ) ____Other_____

Reproductive Health

Check if you have ever given birth. ____Yes

How many births vaginally?____ How many births by C-section? ____

Check if a physician has ever diagnosed you with any of the following:

____Chlamydia ____Dysplasia ____Erectile Dysfunction ____Genital Herpes ____Gonorrhea ____Human Papillomavirus (HPV) ____Impotency ____Syphilis ____Infertility ____Cystitis ____Menopause ____Prostate Enlargement ____Testicular Dysfunction ____Uterine Fibroid ____Vaginal ____Yeast Infections (chronic) ____Other _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials:_____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate. I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy • The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment. • The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions. • The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. • This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. • Patients have the right to file a formal complaint with our privacy official about any suspected violations. • This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage. You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable. I hereby authorize this practice to release any medical or other information required by third party payors, including

government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials:_____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Initials:_____

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear. You are the decision maker for your health care. Part of the role of this clinic is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. The nature of the chiropractic analysis and treatment The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement. Analysis/ Examination / Treatment As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic. The material risks inherent in chiropractic adjustment. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users. The availability and nature of other treatment options. Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers • Hospitalization • Surgery If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers to remaining untreated. Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initials:_____

Signature: _____ Date: _____

919 Spine

Patient waiver for non-covered services

Patient's Name: _____ Date: _____

Your insurance does not pay for all your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and we recommend that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your physician are listed below:

20560 (Needling)	$25.00
20560C (Needling)	$25.00
6A931ZZ (Shockwave)	$100.00
97140 (Medicare- Soft Tissue)	$20.00

The total cost for services/Items recommended by your physician: $_____

I acknowledge that that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name_____

Patient Signature_____

Name of Parent or Legal Guardian (if applicable) _____

Signature or Parent or Legal Guardian (If applicable) _____

Date:_____

This form must be signed by the patient or legal guardian <u>PRIOR</u> to receiving any non-covered services or items and must be maintained in the patient's medical record.