

GOLDSBORO SPINE CENTER, PLLC

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Social Security No.: _____ Where Employed: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

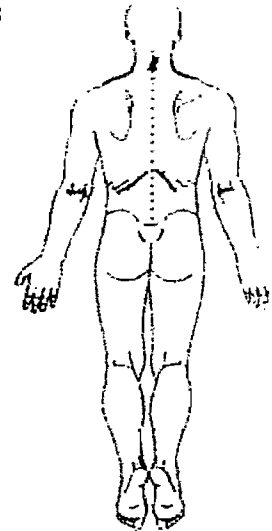
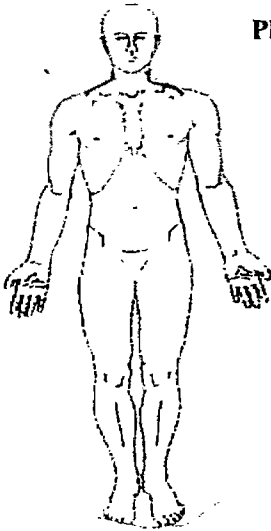
Married _____ Single _____ Widower _____ Separated _____ Divorced _____

Name of insurance company? _____	
Card Holder Name: _____	D.O.B. _____ SS# _____
Relationship to cardholder: _____	Cardholder's Place of Employment: _____

Present Health Problems –In order of importance, please list the complaints in which you are seeing the Doctor:

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

Please mark the areas of your complaint on the illustration below:
P = Pain N = Numbness T = Tenderness S = Spasm



Back

Please answer the following questions: (circle and write in blanks)

Is this pain due to an accident? Y or N

If so: **please let the receptionist know immediately** Date of Accident: _____

Patient initials _____ Date _____

Patient Name _____

Please answer the following questions: (circle and write in blanks)

Have you ever had any pain like this before? Y or N

If so: When? _____

Does it radiate anywhere (up, down, left, or right?) _____

Have you seen any other Drs. for this pain? Y or N

If so: whom did you see? _____ How long ago did you see him/her? _____

What was the Progress: Better Worse Same

What is the pain on a scale of 1-10 when the pain is at its worst: (with 10 being the worst)? _____

Describe the pain please: (throbbing, stabbing, burning, numb, dull ache.) _____

Does anything make it feel better? (Ice, Heat, Massage, Tylenol, Ibuprofen, Excedrin, Aleve, or others)

If so: what have you tried? _____

Does anything make it feel worse (specific movements, sleeping or work posture, activities, etc) _____

When does the pain bother you? (Please circle) Night Day Constant Occasionally Daily Weekly

Has your pain caused you to miss any work or school? Y or N

If so: how much? _____

Are you taking any medications? _____

If so: how much and how often? _____

Have you ever been hospitalized? Y or N

If so: when and why? _____

Have you had any surgeries? Y or N

If so: when and what surgeries? _____

Personal Habits: Smoker? Y or N If so: how much, how often? _____

Alcohol? Y or N If so: how much, how often? _____

Vitamins? Y or N If so: how much and what kind? _____

Exercise? Y or N If so: how much and what kind? _____

Date of last menstrual cycle _____ Are you currently pregnant? Y or N

****If you are pregnant please notify the Doctors and staff immediately*****

**Following today's consultation, if the doctor feels you can benefit from chiropractic care, he/she will make specific recommendations for examination procedures in order you fully understand your condition. At the completion of your examination, you will be scheduled for a separate appointment for the doctor to review these findings with you and make recommendations for your care. We are committed to providing you with the best chiropractic care possible in a caring environment, and have established financial policies consistent with that goal. You are expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Details of available investment options will be discussed with you when the doctor goes over your specific recommendation for care during your report of findings, which will typically be scheduled on our next business day. You are responsible for any and all expenses incurred in the collection of any overdue account. There will be a \$25 returned fee for any returned checks. We reserve the right to charge our typical adjustment fee for missed appointments without prior notification. X-rays remain property of this office and cannot be released.*

***In order to maximize your treatment at the Goldsboro Spine Center, PLLC, group therapy is required as part of the treatment process. Disclosure of Private Health Information is required in order to carry out this procedure. A signature below states that you release the use of that information under HIPPA guidelines. A signature will also authorize your consent to release your health information to your insurance company, which allows them to make any contributions to your care directly to Goldsboro Spine Center, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you or on your behalf.*

Signature of Patient: _____

Date: _____

How did you hear of our office? _____

Patient Name _____

GOLDSBORO SPINE CENTER, PLLC

FAMILY HEALTH HISTORY

Please take a few moments to complete the following... the better you fill it out, the better it will help us to treat your condition. Thank you for your cooperation.

Place an **X** in the boxes that apply

	SELF	SPOUSE	CHILD	OTHER FAMILY
Back Pain				
Neck Pain				
Headaches				
Auto Accident				
Work Accident				
Pinched Nerve				
Allergies				
Scoliosis				
Arthritis				
Asthma				
Carpal Tunnel				
Fatigue				
Diabetes				
Cancer				
Stroke				
Kidney Disease				
Heart Disease				

Signature _____

Date _____



Goldsboro Spine Center, PLLC

Goldsboro Spinal Care & Rehabilitation

605 Spence Avenue, Goldsboro, NC 27534

(919) 751.0555 • Fax (919) 751.3001

www.goldsborospinecenter.com



CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION SERVICE AGREEMENT AND ACKNOWLEDGMENT

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

You have the right to request that we do not disclose your health care information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your request if we have already released your health information before we receive your request. If you were required to give your authorization of a condition while obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorize you to use or disclose my health information in the manner described above. I have read your consent policy and agree to the terms. I am also acknowledging that, if I request, I can receive a copy of this consent and authorization form.

Initial _____

I acknowledge that any gift certificate that I may present in this office is not redeemable for cash. I also acknowledge that if I wish to receive any additional services that are not described on the gift card, I am responsible for payment for those services. Any discounted or free services described on the gift certificate are only applicable on the day that the gift certificate is presented.

Printed Name _____

date _____

Signature _____
(Or signature of guardian representative)

Goldsboro Spine Center, PLLC Office Policies

- We advise that you follow treatment recommendations given by the doctor.
- Please give 24 hour notice if you are going to miss an appointment.
- We reserve the right to charge a \$25 fee for any missed appointments.
- Payment is expected at the time of service, unless prior arrangements have been made.
- Finances can not and will not be discussed over the telephone, if you should have a question you may address it at your next scheduled appointment.
- There are multiple providers in the office.
- Additional letters or forms requested by the patient will be subject to a \$35 administration fee. Copies of records will be assessed at a fee of: .75 pg 1-25
.50 pg 26-100
.25 100+
- Copies of records requested will be assessed a fee of:
- If there are any questions regarding treatment, treatment recommendation, or insurance please feel free to contact our office immediately to set up a consultation.
- Congratulations on choosing to improve your health!!

(initials)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include; sprain/ strain injuries, irritation of a disc condition , and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations, or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Patient or Legal Guardian Signature

Date